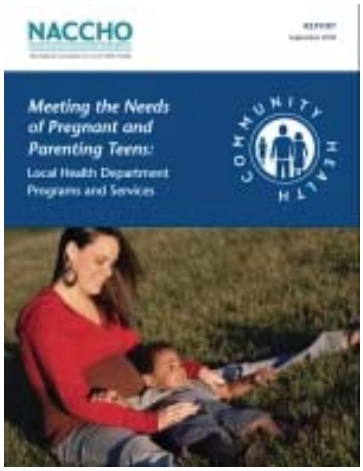
GRANTEE UPdate

September 7, 2009

The Update is a bi-weekly Web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

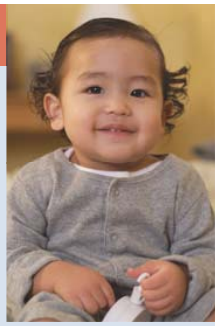
Meeting the Needs of Pregnant and Parenting Teens: Local Health Department Programs and Services



Meeting the Needs of Pregnant and Parenting Teens: Local Health Department Programs and Services report is a joint effort between the National Association of County & City Health Official's (NACCHO) Adolescent Health and Maternal and Child Health Projects. The report highlights local health department (LHD) efforts to address the special needs of pregnant and parenting teens. The four LHDs highlighted in this report are among a number of LHDs that are implementing promising approaches to providing services for pregnant and parenting teens and working to prevent the negative consequences often associated with teenage childbearing and parenting.

Pregnant and parenting teens have needs that are unique to the developmental stages of adolescence, in addition to the needs common to all pregnant women, mothers and fathers. While teen pregnancy prevention advocates continue to place much needed attention on reducing teen pregnancy and teen birth rates, programs and information about teenage pregnancy often focus solely on prevention, with little emphasis placed on providing services for teens that are already pregnant and/or have become parents. In an effort to address this gap in practice and knowledge, this report discusses the importance of addressing the special needs of pregnant and parenting teens in order to improve their health and life outcomes and those of their children.

To view the report, go to pages 8-27 of **The Update**.

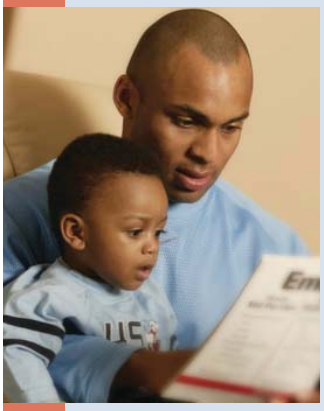


Off to a Good Start

Framing Policy for Early Childhood Health Systems Integration

Thursday, November 12, 2009
8:30 a.m. - 4:30 p.m.

Science Center of Des Moines
401 West Martin Luther King Jr. Parkway
Des Moines, Iowa



KEYNOTE ADDRESS

Health Equity, Life Course Approach, Social Determinants of Health and the Health Practitioner: Challenges and Opportunities to Address Health Disparities

The keynote will provide an overview of the increasing emphasis in child health to address children's healthy development from a whole child perspective and the particular importance for doing so to address health disparities - by socioeconomic status, race, language, culture and geography. It will offer suggestions on how the current Off to a Good Start Coalition recommendations might be informed by the emerging emphasis upon this whole child, social determinants approach.

CO-SPONSORED BY

Child and Family Policy Center, Early Childhood Iowa, University of Iowa College of Public Health Institute for Public Health Practice , Prevention of Disabilities Policy Council, Delta Dental of Iowa Foundation, Child Health Specialty Clinics, Iowa/Nebraska Primary Care Association, and the Iowa Department of Public Health

DE and IDPH Working Together to Provide Planning Resources to Iowa Schools

The Iowa Department of Education (DE) and the Iowa Department of Public Health (IDPH) are working together to prepare for the 2009-2010 influenza season and are providing materials to assist Iowa's K-12 school officials in their 2009-2010 influenza season planning. The *Technical Report for State and Local Public Health Officials and School Administrators on CDC Guidance for School (K-12) Responses to Influenza During the 2009-2010 School Year* is available at www.cdc.gov/h1n1flu/schools/technical report.htm. There are recommendations for conditions of "similar severity as in spring 2009" and recommendations for conditions of "increased severity." Currently, the severity of illness associated with the circulating strains of influenza is similar to spring 2009. Should the severity increase, the DE and IDPH will issue additional communications to schools recommending a shift to the "increased severity" recommendations.

In addition, the CDC has a communications toolkit to help districts prepare for the flu for schools with grades K-12 is available at www.cdc.gov/h1n1flu/schools/toolkit/pdf/schoolflutoolkit.pdf. The toolkit contains fact sheets for parents, staff, and students, signs for posting in schools, and template information letters that schools can distribute.

DE and IDPH are working on materials to assist Iowa schools. This information can be found at www.idph.state.ia.us/h1n1/schools.asp. The materials include a letter template for schools to distribute to parents/guardians. The template provides tips for keeping students healthy and discusses the importance of excluding ill children until 24 hours after fever resolves absent the use of fever-reducing drugs. Advice and a fact sheet with tips for discussing influenza with children in order to minimize stress and confusion is also provided.

Environmental cleaning and disinfection resources including a general use fact sheet and quick guide for schools are also available. The information provides recommendations for prioritizing cleaning efforts and clarification about the types of cleaning products appropriate for influenza.

Descriptions of school reporting and surveillance systems are also available. Schools are asked to report absenteeism when 10 percent or more of the total enrollment is absent on any given day. Reports can be made by calling the IDPH Center for Acute Disease Epidemiology at 800-362-2735 or by faxing the form available at www.idph.state.ia.us/adper/common/pdf/iowa_school_absenteeism.pdf to (515) 281-5698. The Iowa Influenza Surveillance Network (IISN) is recruiting schools to participate in the surveillance program. Additional information is available at www.idph.state.ia.us/adper/common/pdf/flu/flu_brochure.pdf. The CDC has developed an online novel influenza A (H1N1)-related school dismissal reporting system. Visit www.idph.state.ia.us/h1n1/schools.asp for a description.

continued on next page

DE and IDPH Working Together to Provide Planning Resources to Iowa Schools

continued

The DE strongly encourages school districts to collaborate with their local public health department on influenza planning activities. For questions about novel influenza A (H1N1) vaccine distribution in the local community, please contact your local public health departments. Access the IDPH Web site frequently for Iowa-specific updates.

For more information, contact the Centers for Acute Disease Epidemiology at the Iowa Department of Public Health (800-362-2736) or Charlotte Burt at the Iowa Department of Education at 515-281-5327 or charlotte.burt@iowa.gov. You can also contact Carol Hinton at (515) 281-6924 for questions related to school-age/college children.

Free Dental Clinic

The Iowa Dental Association will hold its second Mission of Mercy free dental clinics 7 a.m. - 5 p.m. September 25 and 26 at the Iowa Speedway in Newton. Patients are seen on a first come, first served basis. This is an opportunity for people of all ages to get a wide variety of dental care.

For more information, go to www.iowadental.org/events_calendar/iowa_mission_of_mercy.cfm.

Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement

The Institute of Medicine (IOM) is recommending much more granular standardized data collection for ethnicity and language than the current OMB race and Hispanic ethnicity categories (www.iom.edu/CMS/3809/61110/72796.aspx).

These recommendations are being reviewed by Healthcare Information Technology Standards Panel (HITSP) in its work on standards harmonization for Electronic Health Records (EHRs).

Please note that Recommendation 4-3 includes that health care entities should collect language data including “sign language(s) for spoken language and Braille for written language.”

The American National Standards Institute (ANSI) established HITSP in 2005 as part of efforts by the Office of the National Coordinator for Health Improvement Technology to promote interoperability in healthcare by harmonizing health information technology standards.

Program Management

Bureau of Family Health Fall Seminar

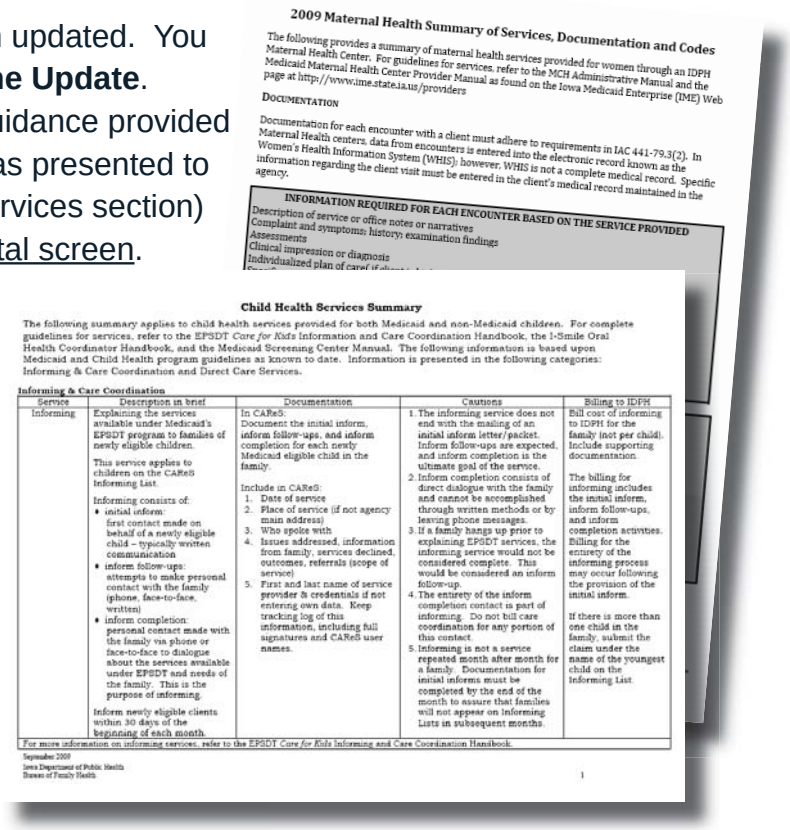
The Bureau of Family Health's Fall Seminar will be held October 5-6, 2009 at the Gateway Hotel and Conference Center in Ames. To view an agenda, go to page 28 of **The Update**. *This is a required meeting for Bureau of Family Health contract agencies*.

Bureau of Family Health Grantee Committee

The next Bureau of Family Health Grantee Committee will be held on October 5, 2009 from 12:15 - 1:45 p.m. in conjunction with the Bureau of Family Health Fall Seminar. *This is a required meeting for Bureau of Family Health contract agencies*. To view survey results from the June meeting, go to pages 29-30 of **The Update**.

Child Health Services Summary

The Child Health Services Summary has recently been updated. You will find the September 2009 tool on pages 31-45 of **The Update**. Modifications on pages 3 and 8 of the tool align with guidance provided at the last I-Smile Coordinators' Meeting. Guidance was presented to document 'Dental Referral' in CAReS (in the Dental Services section) only when a referral is made in conjunction with a dental screen. A 'dental referral' made outside of a screening should be entered in CAReS as dental care coordination.



2009 Maternal Health Summary of Services, Documentation and Codes

The following provides a summary of maternal health services provided for women through an IDPH Maternal Health Center. For guidelines for services, refer to the MCH Administrative Manual and the Medicaid Maternal Health Center Provider Manual as found on the Iowa Medicaid Enterprise (IME) Web page at http://www.ime.state.ia.us/providers

DOCUMENTATION

Documentation for each encounter with a client must adhere to requirements in IAC 441-79.3(2). In Maternal Health centers, data from encounters is entered into the electronic record known as the Women's Health Information System (WHIS); however, WHIS is not a complete medical record. Specific information regarding the client visit must be entered in the client's medical record maintained in the agency.

INFORMATION REQUIRED FOR EACH ENCOUNTER BASED ON THE SERVICE PROVIDED
Description of service or office notes or narratives
Complaint and symptoms; history; examination findings
Assessments
Clinical impression or diagnosis
Individualized plan of care

Child Health Services Summary

The following summary applies to child health services provided for both Medicaid and non-Medicaid children. For complete guidelines for services, refer to the EPSDT *Care for Kids* Information and Care Coordination Handbook, the I-Smile Oral Health Coordinator Handbook, and the Medicaid Screening Center Manual. The following information is based upon Medicaid and Child Health program guidelines as known to date. Information is presented in the following categories: Informing & Care Coordination and Direct Care Services.

Informing & Care Coordination

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Informing	Explaining the services available under Medicaid's EPSDT program to families of newly eligible children. This service applies to children on the CAReS Informing List. Informing consists of: • initial inform: first contact made on behalf of a newly eligible child – typically written communication • inform follow-ups: attempts to make personal contact with the family (phone, face-to-face, written) • inform completion: personal contact made with the family via phone or face-to-face to dialogue about the services available under EPSDT and needs of the family. This is the purpose of informing. Inform newly eligible clients within 30 days of the beginning of each month.	In CAReS: Document the initial inform, inform follow-ups, and inform completion for each newly Medicaid eligible child in the family. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. The informing service does not end with the mailing of an initial inform letter/packet. Inform follow-ups are expected, and inform completion is the ultimate goal of the service. 2. Inform completion consists of direct dialogue with the family and cannot be accomplished through written methods or by leaving phone messages. 3. If a family hangs up prior to explaining EPSDT services, the informing service would not be considered complete. This would be considered an inform follow-up. 4. The entirety of the inform completion contact is part of informing. Do not bill care coordination for any portion of this contact. 5. Informing is not a service repeated month after month for a family. Documentation for initial informs must be completed by the end of the month to assure that families will not appear on Informing Lists in subsequent months.	Bill cost of informing to IDPH for the family (not per child). Include supporting documentation. The billing for informing includes the initial inform, inform follow-ups, and inform completion activities. Billing for the entirety of the informing process may occur following the provision of the initial inform. If there is more than one child in the family, submit the claim under the name of the youngest child on the Informing List.

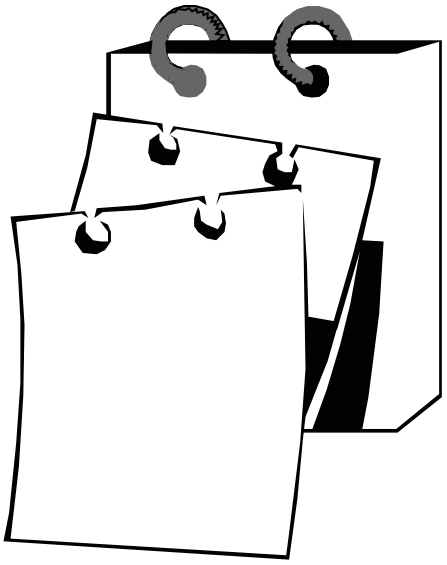
For more information on informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.

September 2009
Iowa Department of Public Health
Bureau of Family Health

This version of the tool will be included in the MCH Administrative Manual updates to be released at the Fall Seminar and is also found on the MCH Project Management Tools Web page at www.idph.state.ia.us/hpcdp/mch_costing.asp.

The **2009 Maternal Health Summary of Services, Documentation and Codes** can be download from pages 46-62 of **The Update**.

CALENDAR OF EVENTS



*September 15-16, 2009

Iowa Family Planning Update

Holiday Inn - Airport, Des Moines

For more information, contact Denise Wheeler at (515) 281-4907.

September 18, 2009

Lead-Based Paint Hazards ICN Workshop

1-3 p.m., ICN

Registration will be available on August 20, 2009 at www.iptv.org/iowa_database/event-detail.cfm?ID=9846. Registration deadline: September 15, 2009. For more information, go to www.iptv.org/iowa_database/event-detail.cfm?ID=9846

*October 5, 2009

Bureau of Family Health Grantee Committee Meeting

12:15 - 1:45 p.m., Gateway Conference Center, Ames

*October 5-6, 2009

BFH-CSCH Fall Seminar

Gateway Conference Center, Ames

October 15, 2009

Adolescent Health Conference

Cedar Rapids

Bureau of Family Health: 1-800-383-3826
Teen Line: 1-800-443-8336
Healthy Families Line: 1-800-369-2229
FAX: 515-242-6013

NAME	***PHONE***	***E-MAIL***
Beaman, Janet	281-3052	jbeaman@idph.state.ia.us
Borst, M. Jane *(Bureau Chief)*	281-4911	jborst@idph.state.ia.us
Brown, Kim	281-3126	kbrown@idph.state.ia.us
Clausen, Sally	281-6071	sclausen@idph.state.ia.us
Connet, Andrew	281-7184	aconnet@idph.state.ia.us
Cox, Jinifer	281-7085	jcox@idph.state.ia.us
Dhooge, Lucia	281-7613	ldhooge@idph.state.ia.us
Ellis, Melissa	281-7044	mellis@idph.state.ia.us
Goebel, Patrick	281-3826	pgoebel@idph.state.ia.us
Hageman, Gretchen	281-7585	ghageman@idph.state.ia.us
Hinton, Carol	281-6924	chinton@idph.state.ia.us
Hobert Hoch, Heather	281-6880	hhobert@idph.state.ia.us
Hodges, Jenny	281-4926	jhodges@idph.state.ia.us
Hummel, Brad	281-5401	bhummel@idph.state.ia.us
Johnson, Marcus	242-6284	mjohnson@idph.state.ia.us
Jones, Beth	242-5593	bjones@idph.state.ia.us
McGill, Abby	281-3108	amcgill@idph.state.ia.us
Miller, Lindsay	281-7721	lmiller@idph.state.ia.us
Montgomery, Juli	242-6382	jmontgom@idph.state.ia.us
O'Hollearn, Tammy	242-5639	tohollea@idph.state.ia.us
Pearson, Analisa	281-7519	apearson@idph.state.ia.us
Peterson, Janet	242-6388	jpeterso@idph.state.ia.us
Piper, Kim	281-6466	kpiper@idph.state.ia.us
Schulte, Kelly	281-8284	kschulte@idph.state.ia.us
Trusty, Stephanie	281-4731	strusty@idph.state.ia.us
Wheeler, Denise	281-4907	dwheeler@idph.state.ia.us
Wolfe, Meghan	281-0219	mwolfe@idph.state.ia.us

Area code is 515

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

REPORT
September 2009

Meeting the Needs of Pregnant and Parenting Teens:

Local Health Department Programs and Services

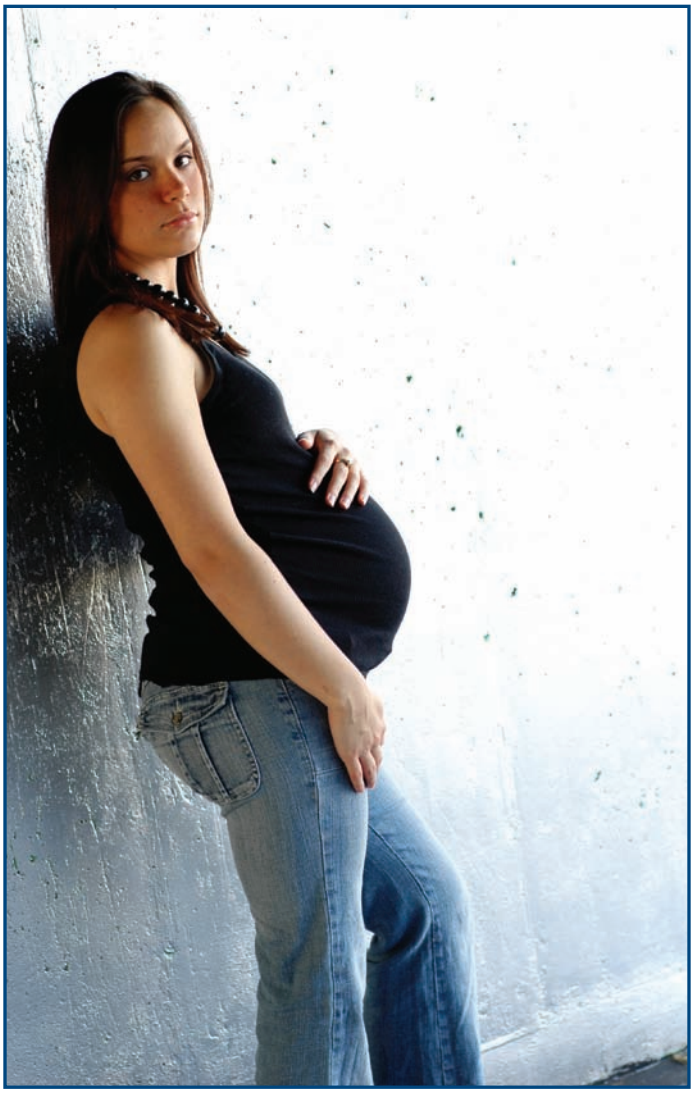
COMMUNITY HEALTH

Meeting the Needs of Pregnant and Parenting Teens: Local Health Department Programs and Services

TABLE OF CONTENTS

Introduction

Pregnant and parenting teens have needs that are unique to the developmental stages of adolescence, in addition to the needs common to all pregnant women, mothers, and fathers. While teen pregnancy prevention advocates continue to place much needed attention on reducing teen pregnancy and teen birth rates, programs and information about teenage pregnancy often focus solely on prevention, with little emphasis placed on providing services for teens that are already pregnant and/or have become parents. In an effort to address this gap in practice and knowledge, this report discusses the importance of addressing the special needs of pregnant and parenting teens in order to improve their health and life outcomes and those of their children. The four local health departments (LHDs) highlighted in this report are among a number of LHDs that are implementing promising approaches to providing services for pregnant and parenting teens and working to prevent the negative consequences often associated with teenage childbearing and parenting.



Background

THE IMPACT OF TEEN CHILDBEARING

Teenage pregnancy and birth rates in the U.S. have seen significant declines since their most recent peak in 1991[1], but this trend reversed in 2006. The teenage pregnancy rate declined from 117 per 1,000 in 1991 to 72 per 1,000 in 2004. Similarly, the birth rate decreased by 30.5 percent from 61.8 births per 1,000 females ages 15-19 in 1991 to 40.4 births per 1,000 in 2005, the lowest rate in six decades. However, preliminary data from the Centers for Disease Control and Prevention (CDC) on births in 2006 indicate that the overall birth rate for teenage girls rose 3 percent to 41.9 births per 1,000 females ages 15-19, the first increase in the teenage birth rate since 1991, suggesting that effective efforts to reduce the occurrence of teen pregnancy continue to be needed.[2]

Teenage childbearing carries large public costs, due to the medical and social complications that often accompany teenage parenthood. Recent research shows that teen childbearing costs local, state, and federal taxpayers over 9 billion dollars annually. This estimate includes various public sector costs such as healthcare, child welfare, incarceration, and lost revenue because children of teen mothers pay lower taxes over their adult lifetimes.[3] In 2004, taxpayers saved an estimated 6.7 billion dollars from the decline in the U.S. teen birth rate, discussed above. Although many pregnancy prevention programs have not conducted formal cost-benefits analyses, these estimates are suggestive of the potential to generate tangible cost-savings through comprehensive, effective teenage pregnancy prevention programs.

However, while there is a definite need for effective efforts that focus on preventing teen pregnancy in order to halt the recent increase in the teen birth rate, we can not ignore the fact that teens are still becoming parents and that these teen parents need supportive programs and services in order to reduce the risks for teen parents and their children.

Research shows that teenage pregnancy is associated with medical-related risks for the teen mother and infant and developmental risks for the growing infant. When compared to their older counterparts and their children, teen mothers and their infants are more likely to experience poor clinical outcomes such as pre-term delivery, anemia, low-birth weight, and infant mortality.[6,7] Multiple studies also demonstrate that children born to teenage mothers perform more poorly on various developmental assessments and academic achievement measures in areas of reading comprehension, mathematics, and vocabulary tests compared to children of adult mothers.[8,9] While some members of the general public have the misconception that pregnancy-related complications and outcomes

experienced by teen mothers and their children are caused by age-related biological factors, research suggests otherwise. Clinical medical research presents strong evidence to suggest that factors such as the delayed confirmation of pregnancy, delayed commencement of and inadequate prenatal care, lower compliance with medical advice, and maternal history of adverse childhood experiences are stronger predictors of poor pregnancy outcomes in teenagers.[3,4] Additionally, the differences observed in developmental measures between children of teen mothers and children of non-teen mothers in many research studies are often confounded by maternal family background. This suggests that maternal family and socioeconomic background, which are risk factors for early childbearing, are also risk factors for poor childhood developmental outcomes.[5,6] This evidence supports the case of proponents for approaches aimed at pregnant and parenting teens by implying that the social and medical consequences of teen pregnancy can be significantly reduced or eliminated with appropriate resources and programs.

In addition to the aforementioned medical risks, teen parents face a wide range of challenges on their way to becoming successful, contributing adults and parents. Some of these obstacles are related to interruptions in their education that may lead to challenges in obtaining a high school diploma and decreasing their chances of attending college.[4,10] Lack of higher education limits a teen parent's career options and increases their risk for living in poverty.[4] Furthermore, teenage fathers are more likely to face economic and employment challenges than adult fathers, which negatively affects their ability to financially support their children. In a number of cases, many teen fathers are absent and unable to financially support their children, increasing the difficulties that teenage mothers face with parenting.[11]

Lastly, an important issue in need of attention is the high occurrence of repeat pregnancies among teen parents. Despite the fact that 22 to 30 percent of teen mothers under 18 have a second birth within 24 months of their first birth, there is little attention and investment in programs and services to help pregnant and parenting teens avoid a subsequent pregnancy.[7] This highlights the need for greater pregnancy prevention interventions targeting teenage mothers, such as education about and provision of contraception and comprehensive health and social support.

CURRENT SERVICES AND PROGRAMS FOR PREGNANT AND PARENTING TEENS

Programs and services aimed at pregnant and parenting teen mothers typically include a case management component. Generally provided to the teen by school staff or through a community program and/or regular home visits during and after pregnancy, case management serves to connect teens to medical and social services present in the community.[10] Other case management programs are hospital-based, with hospital clinicians and social staff working with teens to ensure they receive routine prenatal and maternal healthcare.[11] Case management and home visitation aspects of teen parenting programs also typically focus on improving personal development, strengthening parenting education, increasing school attendance, and increasing access and usage of medical care services for mother and baby.

> ***"…what we're trying to do now is capture the teen fathers. They're a lost group. They're the ones that have kind of fallen off and we'd like to get them back into it."***
>
> — Montgomery County Department of Health and Human Services

SPECIAL FOCUS: *Young Fathers*

While many existing programs aimed at pregnant and parenting teens are tailored to teen mothers, public health professionals interested in information about programs and best practices aimed at teen fathers often face difficulty finding this information. Although years of research focusing on teen fathers indicates that teen fatherhood is associated with many of the same social consequences associated with teen motherhood, the overwhelming majority of programs that address teen parenting focus solely on teen mothers.[12] This occurs for a variety of reasons, such as the following:

- A majority of fathers involved in teen pregnancies are older

than 20, resulting in fewer teen fathers than teen mothers

- Paternity is more difficult to determine than maternity, making teen fathers more difficult to reach
- Teen fathers may be reluctant to seek help or be identified as fathers for fear of reprisal[16]

Although programs for teen fathers may be more difficult to find as well as to conduct, examples of these programs do exist. There are a number of teen father programs across the country that focus on increasing male involvement in the family unit, transitioning teen fathers into adulthood, providing parenting education, developing life and employment skills, and developing strategies to help improve communication with the mother's family.[9, 13, 16] Some programs use male program staff to recruit participants and serve as positive adult role models for teenage fathers.[19] Consequently, programs aimed at both young fathers and mothers improve the health and life outcomes of their children, who benefit from high quality involvement of both parents in their lives.[9]

LOCAL HEALTH DEPARTMENT ROLE

The issues revolving around teenage pregnancy and parenting make it an important public health concern and a priority for LHDs, especially with the national teenage birth rate increasing for the first time in more than a decade. Local health departments play an integral role in connecting teenage mothers and fathers to the medical and social services that they need, as well as addressing the potential negative consequences that giving birth and becoming a parent while still a teenager presents. Local health departments across the country have successfully addressed teenage pregnancy and parenting in their communities, demonstrating that teen parents can lead successful lives with the help of suitable programs and services. To provide examples of successful local level programs aimed at pregnant and parenting teens, the approaches of four LHDs to teen pregnancy and parenting are described as follows.

Adolescent Family Life Program: San Mateo County Health System and Santa Cruz County Health Department

PROGRAM BACKGROUND

Santa Cruz and San Mateo Counties, both located along California's Pacific coast, are among the most affluent areas of the country. However, staff from both LHDs note that areas of significant poverty are present, many of them reflecting racial and ethnic disparities in income that exist locally. In addition to income disparities, both LHDs state that racial disparities between white and Hispanic/Latino birth rates exist.

Currently, both the San Mateo County Health System (SMCHS) and the Santa Cruz County Health Department (SCCHD) implement the "California Adolescent Family Life Program" (AFLP), which grew out of a demonstration program providing services to pregnant and parenting teens in the 1980s. The program's main goals are to do the following:

- Provide support for teen clients through case management
- Encourage the development of high quality relationships with and between teens and their families
- Encourage healthy lifestyle decisions
- Increase the utilization of healthcare resources
- Increase the delivery of healthy babies
- Encourage and increase school attendance
- Prevent unintentional pregnancies among teens

> ***"I think the strength of California's Adolescent Family Life Program is that they've kept the goals broad. That has enabled those of us on the local level to identify who are we really serving and tailor our program accordingly."***
>
> —Santa Cruz County Health Department

The broad nature of the state's goals has enabled SCCHD and SMCHS to tailor the AFLP program in a way deemed appropriate to serve the specific needs of pregnant and parenting teens in their respective jurisdictions. In addition, many innovative components of the SMCHS AFLP have been developed and implemented as demonstration projects through a long-term federal grant. Although home visitation is the major component of the AFLP in San Mateo and Santa Cruz, SMCHS and SCCHD have both incorporated additional components into the program.

TEEN PARENT PROGRAM: SANTA CRUZ COUNTY HEALTH DEPARTMENT

PROGRAM PARTICIPANTS

In Santa Cruz, the AFLP is locally known as the "Teen Parent Program." The program primarily receives referrals from schools, hospitals, and clinics, and is open to pregnant and parenting females 18 years old and younger and teen fathers younger than 21. The program's clients are primarily females. However, teen fathers can enroll in the program if they have daily responsibilities for the child and are able to meet with the nurse according to AFLP standards.

KEY PROGRAM COMPONENTS

After acceptance into the program, teens are each assigned to public health nurses employed by SCCHD. Targeted interventions are developed for teen clients based on structured assessments conducted by the public health nurses. These interventions focus on promoting the health of mother and child. Home visits are enhanced by the addition of educational modules (developed by the program's public health nurses) on topics such as fire safety, vitamin use, dental hygiene, and nutrition. During times of great program demand, for instance at the start of a new school year, referrals to the program are prioritized by age (with younger teens taken into the program first) and risk factors, including a history of domestic violence and lack of school attendance. Because most of the teen parents remain in the program for 12-15 months, some even staying for up to five years, the program has been able to provide pregnant and parenting teens with caring, healthy, and substantial relationships with adults. SCCHD believes these relationships are essential in improving life outcomes for teens and their children.

SCCHD staff members working on the project have learned the importance of building quality measures into the program and

"We believe they will succeed. We also know that a caring relationship with an adult is a key factor to that success, and for many of them we can become that caring adult."

—Santa Cruz County Health Department

maintaining a framework that encourages continual learning and improvement. For state-level evaluation purposes, data for each client is collected at intake, after pregnancy, and every six months thereafter. For SCCHD's evaluation purposes, public health nurses collect specific outcome data (such as infant immunizations, graduation rates, family planning choice, breastfeeding, repeat births, and seat belt and car seat use) when a client's case is closed, using the aggregate data to identify areas of improvement to focus on for the following year. For instance, educational modules on fire and home safety were developed and smoke alarms were distributed to selected families after the program's nurses realized that the outcome data concerning hazards in the child's environment was poor throughout the year. By being directly involved in the evaluation of the program, nurses view quality improvement as an integral component of their work and a way to achieve personal and programmatic goals.

COMMUNITY PARTNERSHIPS AND COLLABORATIONS

The Teen Parent Program receives referrals from schools, hospitals, clinics, and family resource centers, but the relationship with these partners goes beyond a referral network. As primary case managers for program participants, public health nurses collaborate with these partners to ensure that services and care received by the teen are not duplicated but instead effectively coordinated. Together, SCHHD and its partners work together to provide services to pregnant teens.

PROGRAM'S IMPACT

SCCHD emphasizes the cultivation of a caring relationship between each teen client and an adult. Through the Teen Parent Program, staff members have realized the importance of helping each teen believe in their personal ability to be successful. By promoting youth development and resiliency, staff members believe that pregnancy can serve as a catalyst for improvement.

ADOLESCENT FAMILY LIFE PROGRAM: SAN MATEO COUNTY HEALTH SYSTEM

PROGRAM PARTICIPANTS

In terms of positively impacting the lives of pregnant and parenting teens, SMCHS's AFLP places emphasis on not only decreasing the rate of repeat teenage pregnancies but also on strengthening the education and mental health of program participants. The SMCHS's AFLP targets female pregnant or parenting teens, ages 13 to 18, as well as their male partners or young fathers up to the age of 27. A large portion of the program's clients are females who are referred to the program during their first trimester. However, parenting males and females can enroll in the program as long as they are within the target age range and can remain in the program until the mother is 20 and the father is 27.

KEY PROGRAM COMPONENTS

Through the implementation of their version of the AFLP, SMCHS staff members have witnessed firsthand the successful outcomes of using public health nurses and community health workers (both employed by SMCHS) to conduct home visits, as their different strengths complement each other and address the range of health and social needs that are specific to pregnant and parenting teens. In addition to seeing clients in the home, nurses and community health workers also meet clients in local schools and clinics. Visits primarily focus on health education, mental health screenings, and linking clients to health, education, housing, and other necessary resources in the community. Public health nurses also provide prenatal, postpartum, and infant assessments in the home. While each of the program's clients receives the home visitation case management component of the program, some clients are

referred to outside mental health services or social support groups, depending on need.

In addition to including the core AFLP component of home visitation, SMCHS's AFLP also incorporates mental health services, social support and youth development groups, and occasional family-centered social activities into its work with pregnant and parenting teens. The program's mental health component includes a variety of unique mental health services which are primarily offered in the home by a Marriage and Family Therapist, such as individual and/or dyad therapy and art therapy. Additionally, the program has three social support and youth development groups that are conducted within the community, including a "Young Dads" group that provides social support and parenting classes for young fathers. Mental health services and support groups are aimed at decreasing depression, eliminating social isolation, and improving functioning and stability over time.

SMCHS's AFLP has had significant success in engaging young fathers and involving them in the family unit. This success has been attributed to the case manager assigned to young fathers, who has been able to use his own experiences as a young father to conduct outreach and assist young fathers in identifying their needs. Through case management and support groups, SMCHS addresses the needs of young fathers in the program, including the need for parenting education, educational/training resources, and legal information (e.g., child custody, child support, paternal rights information).

COMMUNITY PARTNERSHIPS AND COLLABORATIONS

Not only has SMCHS's AFLP been successful in engaging young fathers, but it has also succeeded in building collaborations with community partners. Through advocacy and collaborations with other organizations, San Mateo has been able to impact participants' needs for education, mental health services, childcare, and legal advice. SMCHS often works with county youth health centers, a collaborative group of youth services providers, prenatal providers, school districts, and local legal aid societies, who are instrumental in providing teen-specific legal information to participants. The AFLP often serves as a referral source for these partners.

PROGRAM'S IMPACT

By removing barriers to positive health and health services, an issue faced by many pregnant and parenting teens, both SCCHD and SMCHS have seen high childhood immunization rates of children in the program (97 and 90 percent, respectively), low numbers of preterm and low birth weight infants born to program participants, and significant percentages of program clients who are enrolled in school.

LESSONS LEARNED

SCCHD and SMCHS have both learned various lessons from implementing the AFLP in their respective counties. The following are of utmost importance to SCCHD:

- Actively monitoring the funding and billing of services, while remaining flexible and open to many funding sources
- Building quality measures into the program and maintaining a mindset of continual learning and improvement
- Nurturing relationships with community partners

SMCHS has learned the following:

- Home visitation models are successful in reducing barriers to accessing health and other services for pregnant and parenting teens
- Mental health screenings and other services are vital components of its program
- Developing and maintaining relationships with as many community partners as possible is integral in attaining program goals

> ***"They always have various needs, including issues with childcare, finances, jobs, mental health, education, legal concerns, health, support, custody, and restraining orders. The way that we've been able to make an impact with those needs is primarily through the case managers, their public health nurses and community workers, and creating linkages to community resources. Really advocating for the clients and helping them navigate the system is essential. "***
>
> — San Mateo County Health System

The School and Community Health Services Teen Pregnancy Teen Parenting Case Management Program: Montgomery County Department of Health and Human Services

PROGRAM BACKGROUND

The Montgomery County Department of Health and Human Services (MCDHHS) serves the large, ethnically and socioeconomically diverse population of Maryland's Montgomery County, located just outside of Washington, DC. To address the specific needs of teen parents in the county, MCDHHS developed the "Teen Pregnancy and Teen Parenting Case Management Program," a multifaceted intervention that grew out of the department's existing School Health Services Division in the early 1980s. Since then, a partnership has developed between school and Community Health Center (CHC) nurses to provide a wide range of services and support for pregnant and parenting teens, both inside and outside of the school setting. MCDHHS's Teen Pregnancy and Teen Parenting Case Management Program is supported by a combination of private, local, and state funding.

PROGRAM PARTICIPANTS

The Teen Pregnancy and Teen Parenting Case Management Program is open to all pregnant and parenting teens, although most teens enter the program during pregnancy. MCDHHS does not target any specific population; however, the department has begun to address the steady increase in Latino teen birth rates. Program staff are trained in conducting outreach to the county's Latino families and teens to ensure that the program's message is sensitive to the culture and values of this growing population.

KEY PROGRAM COMPONENTS

The Teen Pregnancy and Teen Parenting Case Management Program's main goals are to do the following:

- Ensure a birth weight of at least 5.5 pounds among children born to teen clients
- Keep program participants in school
- Prevent repeat teen pregnancies among program participants

To accomplish these goals, the program consists of two main components which are home visitations conducted by CHC nurses employed by MCDHHS and school-based health education carried out by MCDHHS's school nurses. Together, school and CHC nurses located throughout the county work seamlessly within a case management framework.

School nurses are often the program's first point of contact with students entering the program, and remain in close contact with teen clients throughout the duration of their involvement in the program. In addition to providing support and educational services on an individual basis, school nurses also facilitate parenting groups in high schools with at least four pregnant or parenting students, on an at least bi-monthly (but often once a week) basis during the school day. Although the groups do not follow a set curriculum, they do have specific goals such as improving self esteem, teaching students how to identify and express feelings, and providing education, information, and opportunities for discussion. By participating in these support groups, pregnant and parenting students gain information on topics such as positive parenting, proper prenatal care, contraceptives, graduation, and county resources. These groups also give participants the opportunity to meet and engage with other teen parents. Even though the parenting groups are primarily composed of females, teen fathers who are attending high school are always invited to participate in the group when indentified by school nurses. Teen fathers are also referred to the county's "Responsible Father's Program," which uses mentoring and support services to encourage young fathers to be positive role models in their children's lives.

In addition to support received within the school setting, teen mothers also receive support from an assigned CHC nurse, who may also case manage parenting students who did not return to school. CHC nurses conduct home visits and connect students

to necessary resources, such as medical assistance and maternity programs. Home visits take place a minimum of three times while the client is pregnant and every other month while the client is parenting. Together, school and CHC nurses provide the necessary support to ensure healthy births while keeping teens in school and moving them closer to their primary goal of high school graduation.

Because the program's school nurses come from different educational and professional backgrounds, MCDHHS has recently placed emphasis on professional development and standardization of the case management process. School nurses are not only trained on general case management but also on teaching methods that take into account the unique neurological and social development characteristics of adolescents. This enhanced training has significantly strengthened the skills of the nurses in regards to educating students and facilitating support groups.

COMMUNITY PARTNERSHIPS AND COLLABORATIONS

MCDHHS supports the county's Interagency Coalition on Adolescent Pregnancy (ICAP) by providing financial and personnel support and other resources for the coalition. The community coalition, with representation from public and private programs and community organizations, has been instrumental in advocating on behalf of the county for increased funding for programs aimed at pregnant and parenting teens. ICAP also works to educate the county's political leaders about the issues concerning teenage pregnancy and parenting. MCDHHS collaborates with ICAP to sponsor an annual teen parent conference that provides educational information and other resources to pregnant and parenting teenage mothers and fathers in Montgomery County.

PROGRAM'S IMPACT

The program has been successful in keeping repeat pregnancies among their clients down to 1.2 percent over the past four years. Furthermore, program staff note that the case management component of the Teen Pregnancy Teen Parenting Case Management Program continues to have a substantial impact on addressing the need for social support and advocacy expressed by teen clients. MCDHHS believes that pregnant and parenting teens are often stigmatized and left without a voice. School nurses within the program serve as advocates for the teens and the program provides teens with multifaceted support that is necessary to attain healthy life outcomes.

> ***"We want to see them graduate. We know that education is the key to not only their future, but their child's future. Our primary focus is to keep them in school."***
>
> — Montgomery County Department of Health and Human Services

LESSONS LEARNED

After implementing the program for a number of years, MCDHHS has learned many lessons, including the following:

- Education is of utmost importance, not only for the students but also for the students' families and the community at large
- Encouraging parenting teens to stay in school is just as essential as building a community awareness of the significance of education for the entire community
- An emphasis on data collection and data analysis is necessary in understanding shifting demographics and changes in the needs of the population served, as well as how this impacts service delivery models

The Teen Parent Program:
St. Paul-Ramsey County Department of Public Health

PROGRAM BACKGROUND

The St. Paul-Ramsey County Department of Public Health's (SPRCDPH) "Teen Parent Program" is an innovative intervention aimed at pregnant and parenting teens in Minnesota's geographically smallest county, containing the state's second most populated city of St. Paul. Focusing on ensuring that pregnant and parenting teens successfully complete high school, the current Teen Parent Program began out of a strong interest in teenage pregnancy and parenting on the part of the Ramsey County's Board of Commissioners, SPRCDPH, the County's Employment Services, and the Human Services Department.

This interest eventually led to the development of a new collaborative program that integrated the existing nurse home visitation program for pregnant and parenting teens with the "Minnesota Family Investment Program" (MFIP), the state's economic support program for low income families with children, implemented by the County's Workforce and Human Services Departments. This new program recognizes that linking the relationship-based public health nursing component of the Teen Parent Program with school attendance monitoring would improve health outcomes for young parents. It also ensures that all teens in school receiving MFIP would benefit from coordinated, streamlined public health nursing and MFIP services. The Teen Parent Program is funded by third party payments for home visits, tax levy dollars, Title V MCH Block Grant funds and other state and county funding streams.

PROGRAM PARTICIPANTS

The majority of prenatal referrals to the Teen Parent Program come from area schools. Although the program strives to provide services to teens as early in their pregnancy as possible, a number of teens under 18 are referred by hospitals following delivery. Additionally, a significant portion of young parents in the program are referred by MFIP. In order to receive MFIP assistance in Ramsey County, teens who attend school (versus work) are required to have nurse or social worker home visits through the Teen Parent Program.

KEY PROGRAM COMPONENTS

The Teen Parent Program's main objectives for pregnant and parenting teens are to do the following:

- Promote healthy teen and infant outcomes
- Promote secure maternal-child attachment and healthy interaction between parent and child
- Prevent subsequent teenage pregnancies
- Promote high school graduation or GED completion
- Increase long term self sufficiency potential

For children born to teen parents, the program's objectives are to do the following:

- Promote positive growth and development of the child
- Ensure adequate immunizations and prevent injuries
- Ensure school readiness

In order to achieve these objectives, the health department utilizes three components—nurse home visitation services, social work services, and educational support.

In this relationship-based program, each teen enrolled in the program receives home visits from a public health nurse, employed by SPRCDPH. Health education parenting assistants often assist the public health nurses in implementing the teen's

public health case plan. Teens often request that other family members and young fathers participate in the visits. Home visits occur weekly, biweekly, or monthly depending on the needs of the teen and child. These visits focus on addressing the teen's and child's health, positive parent-child interaction, increasing the teen's self sufficiency (through high school graduation or GED completion), and promoting family spacing. Teens continue to receive home visits until the nurse and teen mutually agree that the teen no longer has a public health nursing need, displays that she has a support system, has an adequate connection to health and community services, positively interacts with her child, and the infant/child is developing within normal limits. Home visits are supplemented with social worker visits, based on client need. The social workers provide educational MFIP services to enrolled teens. In 2008, SPRCDPH launched its "Nurse Family Partnership" program that serves pregnant teens referred to the Teen Parent Program prior to 28 weeks gestation.

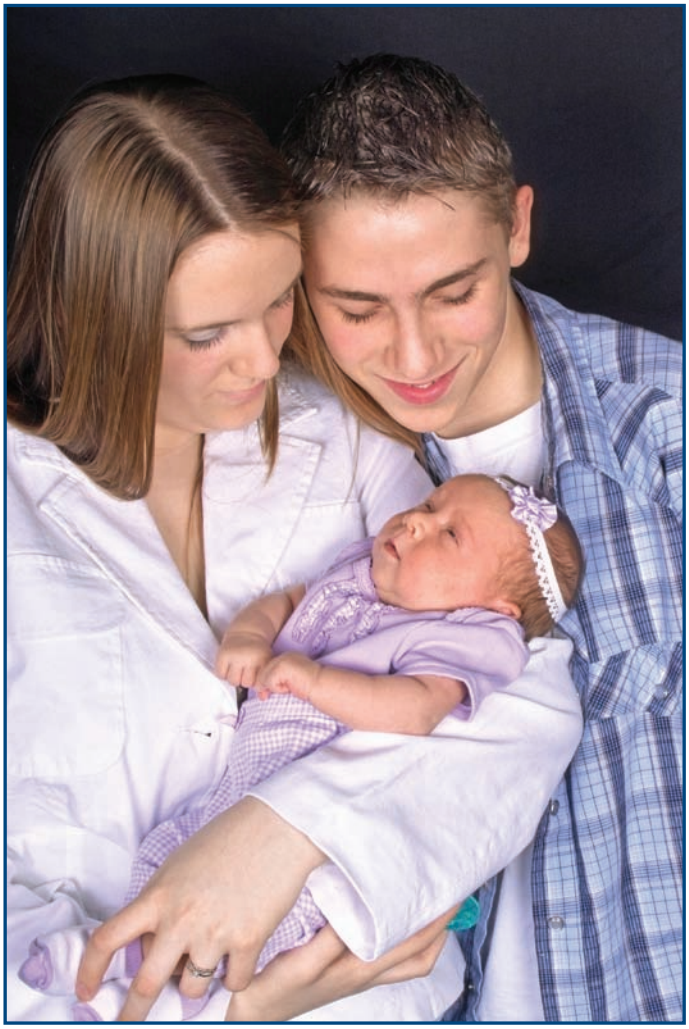
> ***"…as staff have worked with this program, they have had the benefit of seeing a teen graduate or receive an award. Students have credited their public health nurses with encouraging change. Staff now see their value and the importance of these teens graduating from high school and breaking the pattern."***
>
> —St Paul- Ramsey County Department of Public Health

Social workers also facilitate monthly meetings for teens receiving MFIP who are enrolled in school and no longer receiving public health nursing home visits. This specific support group focuses on working with teens to develop and support the accomplishment of their personal goals, moving participants toward high school graduation or GED completion, continuing to connect them with community support and services, and developing effective problem solving skills. These groups are held in a community building that houses many other resources available for teens.

To address their education related goals, the Teen Parent Program's public health nurses and social workers work with teens to enroll in school, reduce personal or family barriers to school attendance, secure affordable childcare, and obtain bus transportation cards when school bus service is unavailable. These nurses and social workers also monitor participants' school attendance and progress and coordinate with the county's Human Services Financial Workers to implement the state's MFIP requirements.

COMMUNITY PARTNERSHIPS AND COLLABORATIONS

The Teen Parent Program collaborates closely with area schools. The SPRCDPH's strong collaboration with St. Paul's public schools and location within the Public Health Department facilitates the monitoring of school attendance and progress. Additionally, the department is able to secure attendance and progress records for teens attending charter schools, alternative schools, and GED programs. For students receiving MFIP, the health department's nurses and social workers can monitor their compliance with MFIP's 80 percent school attendance and progress requirement. Noncompliance can result in the



reduction of financial assistance. Although the Teen Parent Program is limited in its ability to enforce school attendance for students not receiving MFIP, the strong relationship between the teen and his/her public health nurse and social worker encourages school attendance.

The SPRCDPH's long-term role in teen advocacy has also encouraged the program's collaboration with new partners to promote system change. Examples of such efforts include a pilot project to reduce childcare barriers to school attendance; a program with the Workforce Department to pay, when other funding sources are not available, for teen vocational, cognitive, and psychological assessment; and a community-based program that provides funding for Certified Nursing Assistant training and testing, driver's education, and furniture vouchers. As MFIP summer educational requirements changed, the Teen Parent Program collaborated with the County's Workforce Department and Goodwill Easter Seals to develop a paid internship and career exploration program for young parents. The program also partnered with the public libraries to develop special summer teen parent-child reading programs and provide computer access and assistance to complete Free Application for Federal Student Aid (FAFSA) forms for enrollment in post secondary programs.

PROGRAM'S IMPACT

The increasing graduation rates of teens receiving MFIP has been attributed to the model's integration of relationship-based public health nursing and social work services with MFIP's requirement of school attendance and progress. Between 2003, when SPRCDPH first partnered with the county's Workforce Program and Human Services Financial Workers to implement the teen MFIP program, and 2008, the graduation rate of teens receiving MFIP increased from 33 percent to 64.2 percent.

LESSONS LEARNED

Some of the many lessons learned by SPRCDPH after implementing the Teen Parent Program include the following:

- Relationship-based support services that promote parenting, health, and family well-being and holding teens accountable for their school performance are important ways to help them achieve their educational goals and increase their self-sufficiency
- To provide teens with a truly beneficial experience, the program must focus on the variables that are essential for teens to be successful both as parents and adults, such as education and self-sufficiency
- A focus on impacting systems and developing novel community partnerships has helped the program better serve its teen population

Challenges Faced by Programs Targeting Pregnant and Parenting Teens

Local health departments face a variety of challenges as they implement programs for pregnant and parenting teens. Some of the most pressing challenges faced by the four local health departments highlighted in this report are described below.

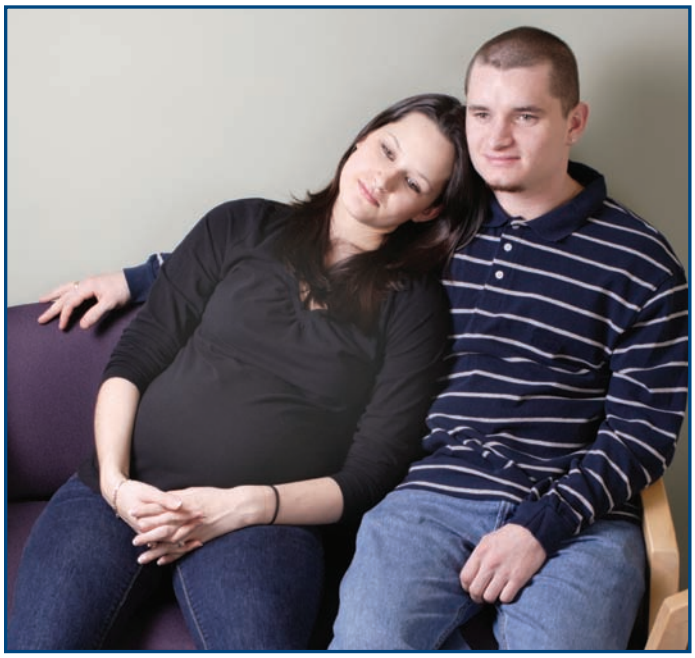
DECREASING RESOURCES

As many local and state governments are faced with budget crises, LHDs and their programs are experiencing decreased funding. Less funding results in staffing reductions and increased workloads. Reductions in the number of staff reduce availability for direct client services, which leads to longer waiting lists for teens seeking the services of these programs. In addition to the effects that decreasing resources have on LHDs, budget constraints are also negatively affecting community partners, many of whom provide critical services to pregnant and parenting teens. Various methods that LHDs can use to prepare for and cope with budget cuts include utilizing a variety of funding streams to finance programs and exploring non-conventional funding sources.

> ***"…we need to hold a certain percentage of our positions vacant, which has meant staff wearing several hats, doing several jobs. It's also meant that we have fewer staff available for direct client services. Right now we have a wait list of about 30 clients…"***
>
> — San Mateo County Health System

CHANGING DEMOGRAPHICS

One health department noted the increasing diversity in the community, which has challenged providers to develop culturally sensitive services that all individuals in the community will feel comfortable using. An increase in the number of non-English speaking teenage clients poses challenges to effective communication between nurses and teens. As a result, service providers (including the health department) need staff members who can speak the languages of their clients. Training staff in being sensitive to other cultures and communicating with non-native English speakers can be effective in addressing changing community demographics. If possible, local health departments can also hire multilingual staff.



COMMUNITY SENTIMENT ABOUT PROGRAMS FOR PREGNANT AND PARENTING TEENS

Although it might be expected that LHDs would experience pushback from the teenage population, greater challenges are posed by others in the community. For one health department, these challenges arise from the overall sentiment that teenage pregnancy prevention, especially for pregnant and parenting teens, is unnecessary. The individuals in the community with this outlook believe that pregnant and parenting teens should fend for themselves because of their prior behavior. This attitude makes it difficult to institute certain prevention activities in the school environment, such as the provision of contraceptives, which would benefit both pregnant and non-pregnant teens. To address negative community sentiment, LHDs can seek to educate the community on the benefits that the whole community receives when pregnant and parenting teens receive adequate services and complete their education.

> ***"We need to educate people that the philosophy of you made your bed now lie in it is not the answer. Teenage parents will not be successful if you say that. We have to do something to help them."***
>
> — Montgomery County Department of Health and Human Services

Recommendations

Despite the challenges that LHDs face when implementing programs for pregnant and parenting teens, it is a worthy and necessary cause. There are a variety of steps LHDs can take to establish new pregnant and parenting teen programs or strengthen existing ones.

BUILDING COMMUNITY COLLABORATIONS

Collaborating with community partners that have a background or interest in working with teens and families is a great way to pull together the expertise and resources of different organizations to reach common goals. Community coalitions can provide structure to partnerships and facilitate the collaborative process.

> *"We're constantly reconnecting and finding other programs in the area, so we can form new partnerships."*
>
> — Santa Cruz County Health Department

TAPPING INTO CREATIVE FUNDING STREAMS

Budget constraints are a challenge that LHDs face more often than not, especially during times of national economic crises. However, identifying and focusing on multiple funding sources can decrease the negative impact that programs experience when one source of funding is reduced or eliminated. Additionally, seeking funding and partnerships from non-traditional programs and sources, such as welfare and social service programs, can be an option for increasing resources available and even broadening the scope of services that the program offers.

UTILIZING CULTURALLY AND LINGUISTICALLY SENSITIVE SERVICES/PROGRAMS

Changing demographics and increasing diversity in areas all across the country demands the creation of culturally sensitive services. In order to meet this demand, LHDs can focus part of their efforts on training staff in cultural competence, which may include recognizing the different value systems in other cultures and effective communication with non-native English speakers.

> *"The federal funding, in particular, has really augmented what we can do with the state and local funding. Some of the really creative pieces came out of the federal grants."*
>
> — San Mateo County Health System

GAINING COMMUNITY BUY-IN

Increasing support in the community for teen pregnancy and parenting programs can help to increase visibility of the issue at the policy level, and thus increase funding. LHDs can educate teens, parents, policymakers, and other community members about the benefits the whole community receives when parenting teens complete their high school education and are able to access the medical and social services they need to ensure healthy outcomes for themselves and their children.

CONTINUED STAFF TRAINING AND DEVELOPMENT

A focus on staff training and development is a necessary component of strong programs for pregnant and parenting teens. Training on working with adolescents and recognizing their developmental needs can serve to increase staff comfort level with working with the adolescent population. Case management training for nurses that focus on teens' clinical and social needs can enhance their ability in dealing with non-medical issues, such as school attendance.

> *"At a time where you have decreasing funds, we need to make sure that everybody knows how those funds are being used and how it supports the whole community to invest in our teens…"*
>
> — Montgomery County Department of Health and Human Services

Conclusion

Over the last decade, strong public health programs have been successful in significantly reducing rates of teenage pregnancy and teen birth. As those rates are slowly beginning to climb for the first time in close to 20 years, LHDs must continue their critical prevention efforts while also providing programs and services for teens that are already pregnant and parenting. Because current data shows that teens who give birth are at a higher risk for harmful medical complications and are more likely than their peers to have social difficulties in life, programs like the ones included in this report are crucial in decreasing those chances.

The programs highlighted in this report exhibit the components of highly successful programs for pregnant and parenting teens. The home visitation component of these programs aids in reducing barriers to accessing pre and postnatal care and support, such as a lack of transportation or knowledge about available services. Home visitation nurses are able to connect young parents to resources in the community, conduct screenings, and provide health education, all within the home. Home visiting is also instrumental in facilitating the development of supportive relationships between teens and knowledgeable adults. Health education is another component of successful programs. Health education provides parents with instruction on a variety of topics that will increase their ability to care for their children and promote their own personal health and wellness, such as prenatal care, positive parenting, home safety, and sexual health. Many successful programs also include social support groups that allow young parents to meet each other and discuss pertinent issues in a supportive environment. Lastly, school completion and academic success is emphasized in all components of successful programs.

Although challenges and barriers abound, the development and maintenance of comprehensive and effective programs is possible. A multifaceted approach that addresses all of the key areas of need for pregnant and parenting teens may not be feasible for one local health department to accomplish alone. However, a coordinated approach that involves community partners can be successful in meeting medical and social needs.

End Notes

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FOR MORE INFORMATION, PLEASE CONTACT:

Tasha Toby, MPH
Senior Analyst
National Association of County & City Health Officials

P (202) 507 4270
F (202) 783 1583

ttoby@naccho.org

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Bureau of Family Health Fall Seminar
October 5-6, 2009
Gateway Hotel and Conference Center
Ames, Iowa

Agenda

October 5, 2009	
Pre-Conference Meetings	
8:00 a.m. – 12:00 p.m.	Family Planning Directors' meeting – Harvest room
9:00 a.m. - 12:00 p.m.	I-Smile Coordinators' meeting – South Prairie (registration for I-Smile Coordinators starts at 8:30 a.m.)
9:00 a.m. – 11:30 a.m.	***hawk-i*** Outreach Task Force – North and South Meadow
Fall Seminar	
12:00 p.m. – 2:00 p.m.	Registration - Lobby
12:15 p.m. – 1:45 p.m.	BFH Grantee Meeting – Central Prairie
2:00 p.m. – 2:15 p.m.	Welcome & Announcements – Garden Room
2:15 p.m. – 2:45 p.m.	Five Year Needs Assessment Overview – *Jane Borst*
2:45 p.m. – 3:15 p.m.	Iowa MCH Needs Assessment and Prioritization Process – *Gretchen Hageman, Lucia Dhooge and Melissa Ellis*
3:15 p.m. – 3:30 p.m.	Break
3:30 p.m. – 5:00 p.m.	Prioritization Process – *Gretchen Hageman, Lucia Dhooge and Melissa Ellis*
5:00 p.m. – 5:15 p.m.	Summary and Next Steps
5:15 p.m.	Adjourn

October 6, 2009	
7:45 a.m. – 8:30 a.m.	Registration / Continental Breakfast – Garden Room
8:30 a.m. – 9:30 a.m.	Needs Assessment Follow-up/Prioritization Results – *Gretchen Hageman, Lucia Dhooge and Melissa Ellis*
9:30 a.m. – 10:00 a.m.	Health Care Reform – *Beth Jones*
10:00 a.m. – 10:15 a.m.	Break
10:15 a.m. – 12:00 p.m.	MCH & FP Program Updates – *IDPH Staff*
12:00 p.m. – 12:30 p.m.	Lunch
12:30 p.m. – 1:30 p.m.	Agency Best Practice Discussion Tables 12:30-12:55 – Round 1 1:00 – 1:25 Round 2
1:30 p.m. – 2:15 p.m.	Perinatal Depression – Behavioral Health – *Dr. Robin Kopelman*
2:15 p.m. – 2:30 p.m.	Break
2:30 p.m. – 3:15 p.m.	Youth Services Panel – *Lindsay Miller, facilitator*
3:15 p.m. – 3:30 p.m.	Wrap Up
3:30 p.m.	Adjourn

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survey title:
Bureau of Family Health Grantee Meeting Edit Title

design survey | collect responses | analyze results

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- Share Responses

current report: Default Report Add Report

Response Summary

Total Started Survey: 25
Total Completed Survey: 25 (100%)

Page: Default Section

1. Which of the following program(s) does your agency provide? Create Chart Download

	Response Percent	Response Count
Maternal Health	**84.0%**	**21**
Child Health	**84.0%**	**21**
Family Planning	28.0%	7
answered question		**25**
skipped question		**0**

2. Did your agency submit a question for the Q & A portion of the agenda, or provide a presentation? Create Chart Download

	Response Percent	Response Count
Yes	20.0%	5
No	**80.0%**	**20**
answered question		**25**
skipped question		**0**

3. Did you find the overall content to be useful and interactive? Create Chart Download

	Response Percent	Response Count

Yes		**76.0%**	**19**
No		8.0%	2
Show replies	Other (please specify)	24.0%	6
		answered question	**25**
		skipped question	**0**

4. What agenda topic did you find to be the most useful? Download

	Response Count
Show replies	25
answered question	**25**
skipped question	**0**

5. Do you have any suggestions for improvement or agenda topics for the next meeting? Create Chart Download

		Response Percent	Response Count
Yes		40.0%	10
No		**60.0%**	**15**
Show replies	Other (please specify)		12
	answered question		**25**
	skipped question		**0**

Child Health Services Summary

The following summary applies to child health services provided for both Medicaid and non-Medicaid children. For complete guidelines for services, refer to the EPSDT *Care for Kids* Information and Care Coordination Handbook, the I-Smile Oral Health Coordinator Handbook, and the Medicaid Screening Center Manual. The following information is based upon Medicaid and Child Health program guidelines as known to date. Information is presented in the following categories: Informing & Care Coordination and Direct Care Services.

Informing & Care Coordination

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Informing	Explaining the services available under Medicaid's EPSDT program to families of newly eligible children. This service applies to children on the CAReS Informing List. Informing consists of: ♦ initial inform: first contact made on behalf of a newly eligible child – typically written communication ♦ inform follow-ups: attempts to make personal contact with the family (phone, face-to-face, written) ♦ inform completion: personal contact made with the family via phone or face-to-face to dialogue about the services available under EPSDT and needs of the family. This is the purpose of informing. Inform newly eligible clients within 30 days of the beginning of each month.	In CAReS: Document the initial inform, inform follow-ups, and inform completion for each newly Medicaid eligible child in the family. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. The informing service does not end with the mailing of an initial inform letter/packet. Inform follow-ups are expected, and inform completion is the ultimate goal of the service. 2. Inform completion consists of direct dialogue with the family and cannot be accomplished through written methods or by leaving phone messages. 3. If a family hangs up prior to explaining EPSDT services, the informing service would not be considered complete. This would be considered an inform follow-up. 4. The entirety of the inform completion contact is part of informing. Do not bill care coordination for any portion of this contact. 5. Informing is not a service repeated month after month for a family. Documentation for initial informs must be completed by the end of the month to assure that families will not appear on Informing Lists in subsequent months.	Bill cost of informing to IDPH for the family (not per child). Include supporting documentation. The billing for informing includes the initial inform, inform follow-ups, and inform completion activities. Billing for the entirety of the informing process may occur following the provision of the initial inform. If there is more than one child in the family, submit the claim under the name of the youngest child on the Informing List.
For more information on informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Re-informing	Providing the informing service anew at a later time for families that 1) could not be reached after multiple attempts or 2) refused care coordination services. Re-informing consists of ♦ Re-inform (initial) ♦ Re-inform follow-ups ♦ Re-inform completion Re-informing involves use of 2 CAReS reports: 1. Re-informing List – No Agency (Client's last discharge reasons was 'Unreachable/Unavailable'.) 2. Re-informing List – In Agency (Client's last care coordination service was 'Care Coordination Refusal'.)	In CAReS: Document the initial re-inform, re-inform follow-ups, and re-inform completion for each Medicaid eligible child in the family. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. The re-informing service does not end with the mailing of an initial re-inform letter/packet. Re-inform follow-ups are expected, and re-inform completion is the ultimate goal of the service. 2. Re-inform completion consists of direct dialogue with the family and cannot be accomplished through written communication or by leaving phone messages. 3. If a family hangs up prior to explaining EPSDT services, the re-inform service would not be considered complete. This would be considered a re-inform follow-up. 4. The entirety of the re-inform completion contact is part of re-informing. Do not bill care coordination for any portion of this contact. 5. Re-informing is provided ♦ every 6 months if the child is under age 2 at time of discharge as unreachable/unavailable or refusal of care coordination ♦ annually for children age 2 or over at time of discharge as unreachable/unavailable or refusal of care coordination.	Bill cost of re-informing to IDPH for the family (not per child). Include supporting documentation. The billing for re-informing includes the initial re-inform, re-inform follow-ups, and re-inform completion activities. Billing for the entirety of the re-informing process may occur following the provision of the initial re-inform. If there is more than one child in the family, submit the claim under the name of the youngest child on the Re-informing List.
For more information on re-informing services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Care coordination	Linking a client to the health care system (medical, dental, mental health or other Medicaid programs/services). It includes: ♦ Providing information about available health and support services based upon family needs ♦ Answering questions about health care coverage ♦ Assisting with establishing medical and dental homes ♦ Advocating for the child and family as they navigate the health care system ♦ Reminding families that well child screenings are due. This involves use of 2 CAReS Reports: 1. Care Coordination List – In Agency (Clients due for a well child screen in agency home.) 2. Care Coordination List – No Agency (Clients due for a well child screen never in an agency home.) ♦ Assisting with scheduling appointments (outside agency) ♦ Follow-up to assure that clients received services ♦ Assisting with missed appointments ♦ Assisting families with referrals for further care ♦ Arranging support services such as medical transportation or interpreter services	In CAReS: ♦ Document care coordination under the Informing and Care Coordination Services category. ♦ Mark "Physical Exam Referral" if the care coordination includes a referral for a medical exam or medical treatment. ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Date of service 2. Place of service (if not agency main address) 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. Time in and time out including a.m. and p.m. 6. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. Must involve phone or face-to-face contacts with the family or provider(s) on behalf of child. 2. Must include linkage to medical, dental, mental health or other Medicaid related programs/services. 3. May not bill care coordination for ▪ written reminders for services ▪ activities in an inform completion ▪ unsuccessful attempts to reach families ▪ activities that are part of the postpartum home visit ▪ activities that are part of direct care e.g., Do not bill cc for o Making CH agency appointments o Reporting lab results to the family/medical home for tests conducted by the CH agency o Referral/arranging appointment for treatment following direct care provided by the CH agency 4. Care coordination to arrange transportation may occur on the same day as a direct care service. 5. Interpretation for care coordination may be billed on the same day as the care coordination service. 6. Medical care coordination may be billed if a dental direct service is provided by other staff (RDH) on the same day (only if no medical direct care was provided). 7. Dental care coordination by RDH may be billed if a medical direct service is provided by other staff on the same day (only if no dental direct care was provided). 8. Do not mark "Dental Referral" in CAReS when it is a part of dental care coordination.	Bill cost of care coordination services (medical and dental) to IDPH per client. Include supporting documentation that identifies payer source (Title V or Title XIX) and contains the number of minutes spent on each care coordination service. Selected Early ACCESS service coordination activities may also be billed to IDPH as care coordination. (See the Early ACCESS Medicaid Matrix.)
For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For guidance on Early ACCESS service coordination activities, see the Early ACCESS Medicaid Matrix.				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Home visit for care coordination	When a home visit is made for the purpose of providing care coordination services. This includes care coordination for a medical/dental/mental health condition to: ♦ Provide information about health care services. ♦ Coordinate access to care ♦ Assist in making health care appointments ♦ Make referral appointments ♦ Coordinate access to needed medical support services (transportation or interpreter services) ♦ Follow-up to assure services were received. A home visit may also be made by an RN to follow-up on a blood lead level equal to or greater than 15 µg/dL. This includes: ♦ A skilled assessment and instructions to the family ♦ Assistance with making and keeping follow-up appointments ♦ Reminding caregiver to notify child's lead case manager if the family moves ♦ Reminding caregiver to inform the child's current and future health care providers of elevated blood lead level	In CAReS: Document the care coordination service. Select "home visit" as the interaction type. Mark "Physical Exam Referral" if the care coordination results in a referral for a well child exam in the medical home. Include in CAReS: 1. Date of service 2. Place of service 3. Who spoke with 4. Issues addressed, information from family, services declined, outcomes, referrals (scope of service) 5. Time in and time out including a.m. and p.m. 6. First and last name of service provider & credentials if not entering own data. Keep tracking log of this information, including full signatures and CAReS user names.	1. Use only face-to-face time to determine minutes of service. Do not include travel time when determining minutes of service. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill child health care coordination for any part of this maternal health visit. 3. If the purpose of the home visit is to provide direct care services, home visit for care coordination cannot be billed. If the purpose of the home visit is for nursing or social work services, use codes S9123 for the home visit for nursing services or S9127 for the social work home visit. (See guidelines below.)	Bill cost of home visit for care coordination to IDPH per client. Include supporting documentation that identifies payer source (Title V or Title XIX) and contains the number of minutes spent on each care coordination service (face-to-face time only). Selected Early ACCESS service coordination activities may also be billed to IDPH as home visit for care coordination. (See the Early ACCESS Medicaid Matrix.)
For more information on the home visit for care coordination, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For guidance on Early ACCESS service coordination activities, see the Early ACCESS Medicaid Matrix.				

Direct Care Services

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Medical transportation (local)	Transportation to *local (in-town)* medical, dental, mental health services. Includes transportation parking fees and tolls.	In CAReS: Document under Health Screening Services category. Mark "Transportation to Health Provider" for in-town transportation services. Include in CAReS: 1. Date of service 2. Who provided the service (e.g. name of cab company) 3. Address of where recipient was picked up 4. Destination (medical provider's name and address) 5. Invoice of cost 6. Mileage if transportation is paid per mile If the Title V agency keeps a service log containing the above information, the service note must include a reference to this record.	1. Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. 2. This does not include out-of-town transportation. Out of town transportation is paid through the county DHS office. The client obtains approval and forms for reimbursement of out-of-town transportation from the local DHS office.	Code A0110: Non-emergency bus (per round trip) Code A0100: Non-emergency taxi (per round trip) Code A0130: Non-emergency wheel chair van (per round trip) Code A0090: Non-emergency by volunteer (per mile) Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip) Code A0170: Parking fees, tolls Bill actual cost of transportation for the date the transportation was provided to the health related appointment.
For more information on transportation services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Interpretation services	Services that include: • Sign language or oral interpretive services • Telephonic oral interpretive services	In CAReS: Document under Health Screening Services category. Mark "Interpretation". For telephonic oral interpretive services, mark 'phone' as the Interaction Type. Include in CAReS: 1. Date of service 2. Name of interpreter or company 3. Time in and time out 4. Cost of service	1. These services are provided by interpreters who provide **only** interpretive services. 2. Interpreters are either employed or contracted by the Medicaid provider agency billing the services. 3. Service providers on staff who are also bilingual are not reimbursed for the interpretation, but only for their medical/dental services. 4. These services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service. 5. This service does not include written translation of printed documents. 6. It is the responsibility of the provider to determine the interpreter's competency. • Sign language interpreters should be licensed pursuant to IAC 645 Chapter 361. • Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).	Code T1013 for sign language or oral interpretive services (15 minute unit) For determining 15 minute units: • 8-22 minutes = 1 unit • 23-37 minutes = 2 units • 38-52 minutes = 3 units • 53-67 minutes = 4 units Reimbursable time may include the interpreter's travel and wait time. Code W5023 For telephonic oral interpretive services (per minute unit)
For more information on transportation services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook and Medicaid's Screening Center Manual.				

The following direct care services provided by a Title V agency are identified in the agency needs assessment and are approved per the annual application for child health services submitted to IDPH.

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Health screening (well child exam)	The initial or periodic well child screen per the Iowa Recommendations for Scheduling *Care for Kids* Screenings (Periodicity Schedule) and as described in the Medicaid Screening Center Manual.	In CAReS: Under Health Screening Services category, mark "Physical exam – Direct" for well child screens provided by the child health agency. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	When providing direct care services, any care coordination related to the direct care is considered part of the direct care service. Do not bill this activity separately as care coordination. Examples include: ▪ Reporting lab results to the family or medical home from tests conducted at the Title V agency could not be billed as care coordination. It is considered part of the direct care. ▪ Arranging an appointment for treatment services following a well child screen provided by the Title V agency could not be billed as care coordination. It is considered part of the direct care. Do not document this activity separately as care coordination. Document any care coordination activity in conjunction direct care as part of the documentation for the direct care service.	Initial screen: Code 99381: 0-12 mo Code 99382: 1-4 yr Code 99383: 5-11 yr Code 99384: 12-17 yr Code 99385: 18-21 yr Periodic screen: Code 99391: 0-12 mo Code 99392: 1-4 yr Code 99393: 5-11 yr Code 99394: 12-17 yr Code 99395: 18-21 yr Use modifier U1 for a screen that results in a referral for treatment. Use diagnosis code V20.2 for children ages 0-18. Use diagnosis code V70.5 for children ages 19-20.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Oral Health Services	Services: ♦ Initial oral screen ♦ Periodic oral screen ♦ Child prophylaxis ♦ Adult prophylaxis ♦ Sealant (per tooth) ♦ Bitewing x-ray, single film ♦ Bitewing x-ray, two films ♦ Bitewing x-ray, four films ♦ Oral evaluation and counseling with primary caregiver for patient under 3 yr of age ♦ Topical fluoride varnish – therapeutic application for moderate to high caries risk patients ♦ Nutritional counseling for the control and prevention of oral disease ♦ Oral hygiene instruction ♦ Dental care coordination (Refer to Care Coordination on page 3.)	In CAReS: • Mark appropriate service under the "Dental Services" category. • Mark "Dental Referral" when a referral for a dental exam or treatment is made in conjunction with a dental screen. ♦ Document dental care coordination under the Dental Services category. Include in CAReS: 1. Time in and time out including a.m. and p.m. for timed based services (Codes D1310 and D1330.) 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. When providing direct oral health services, any care coordination related to the direct care is considered part of the direct care service. Do not bill this activity separately as care coordination. For example: • After completing an oral health screen, making a referral to a DDS for follow-up and treatment cannot be billed separately as care coordination. 2. If an initial screen is provided, use only Code D0150. When providing subsequent screens, use either D0120 or D0145 as appropriate. 3. Code D0145 is billable only for children under three years of age if counseling with the primary caregiver is provided during a screen. 4. For Codes D1310 and D1330, a minimum of 8 minutes must be provided to bill the service. 5. For both sealant applications and bitewing films, report the number of teeth sealed or the number of bitewing films taken, not the number of clients that will receive the service.	Codes: ♦ D0150: Initial oral screen ♦ D0120: Periodic oral screen ♦ D1120: Prophy (age 12 yr. and younger) ♦ D1110: Prophy (age 13 yr. and older) ♦ D1351: Sealant per tooth (posterior teeth up to age 18) ♦ D0270: Single bitewing film ♦ D0272: Two bitewing films ♦ D0274: Four bitewings films ♦ D0145: Oral evaluation and counseling with caregiver (child under age 3) ♦ D1206: Topical fluoride varnish (moderate to high caries risk) ♦ D1310: Nutritional counseling for control and prevention of oral disease (15 minute unit) ♦ D1330: Oral hygiene instruction (15 minute unit)
For more information on oral health direct care services, refer to the I-Smile Handbook and Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Immunizations	Administration of immunizations	In CAReS: Under Health Screening Services category, mark "Immunization". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart, IRIS, or Master Index Card for full description of services provided. In client-based chart, IRIS, or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Assure entry in IRIS.	Typically VFC vaccine is used (at no cost). If a child needs vaccine outside of the VFC cohort, Medicaid can be billed for the vaccine.	Code 90471 for initial administration of vaccine (single or combination), subcutaneous or intramuscular Code 90472 for subsequent administrations of vaccine (single or combination) on same day as Code 90471 or Code 90473. Code 90473 for administration of one vaccine (single or combination) by intranasal or oral means. Bill the appropriate administration code(s) and the code(s) for the VFC vaccine (at $ 0).
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Blood draw	Collection of venous blood by venipuncture Collection of capillary blood specimen Handling or conveyance of specimen for transfer to a laboratory	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify if venipuncture, capillary draw, or handling/conveyance to lab. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in STELLAR.	A blood lead draw and handling/conveyance cannot both be billed. Only one of the three codes can be billed. Note that venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early Access service coordination will be made by the responsible CLPPP.	Code 36415 for venous draw. Code 36416 for capillary draw. Code 99000 for handling and conveyance to lab. Select only one of the above codes for billing.
Blood lead analysis	Lab analysis of blood lead level using the Lead Care II	In CAReS: Under Health Screening Services category mark "Lab-Lead". Include in CAReS: 1. Specify use of Lead Care II. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). If a CLPPP, assure entry in STELLAR.	The Lead Care II is the only CLIA waived testing device approved by IDPH. **Child Health agencies using the Lead Care II must report the results of all blood lead testing electronically to the Bureau of Lead Poisoning Prevention.** If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab for a confirmatory test.	Code 83655 The capillary blood draw (Code 36416) can be billed in addition to the blood lead analysis when using the Lead Care II. Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3. Referral to the Child Health agency for Early Access service coordination will be made by the responsible CLPPP.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Other lab services	Urinalysis Hematocrit level Hemoglobin level Tuberculosis skin test	In CAReS: Under Health Screening Services category, mark the appropriate service. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	If hemoglobin testing is covered by the WIC program, it cannot be billed to Medicaid.	Code 81002: UA Code 85014: Hct Code 85018: Hgb Code 86580: TB
Visual acuity	Screening test of visual acuity, quantitative, bilateral. The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart).	In CAReS: Under Health Screening Services category, mark "Vision". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	This vision screening service cannot be billed in addition to a preventive office visit (initial or periodic health screening).	Code 99173
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Speech audiometry	Speech Audiometry – threshold only	In CAReS: Under Health Screening Services category, mark "Hearing". Include in CAReS: 1. Specify the speech audiometry service provided 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).		Code 92555
Developmental screen	Developmental screening with interpretation and report. This serves to identify children who may need more comprehensive evaluation. Use recognized instruments such as: ♦ Parent's Evaluation of Developmental Status (PEDS) ♦ Ages and Stages Questionnaire	In CAReS: Under Health Screening Services category, mark "Developmental Screen". Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2). Include: • Date of service • Name / copy of screening tool • Results and interpretation • Referrals / action taken • First name, last name, credentials, signature of service provider	Do not use E & M for the following activities which are included in the scope of the developmental screening service: • Explaining the purpose of a developmental screen • Interpretation of results of the screen • Anticipatory guidance and • If indicated, referral to Level II screening	Code 96110
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Nutrition counseling	Medical nutrition therapy - initial nutrition assessment and intervention, face-to-face with the individual Nutrition reassessment and intervention, face-to-face with individual	In CAReS: Under Health Screening Services category, mark "Nutrition Assessment". Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. Use for medically necessary nutrition services beyond those provided through the WIC program. 2. For Codes 97802 and 97803, a minimum of 8 minutes must be provided to bill the service. 3. See guide sheet in MCH Administrative Manual. Assure that criteria for providing nutrition counseling services are met.	Code 97802: Initial nutrition assessment & counseling (15 minute unit) Code 97803: Nutrition reassessment and counseling (15 minute unit) For determining 15 minute units: • 8-22 minutes = 1 unit • 23-37 minutes = 2 units • 38-52 minutes = 3 units • 53-67 minutes = 4 units
Nursing assessment/evaluation	Nursing contact for the purpose of providing assessment and evaluation of a known medical condition such as: ♦ Failure to thrive ♦ Asthma ♦ Diabetes Must be provided by a registered nurse. Must include: ♦ Medical history including chief complaint ♦ Nursing assessment ♦ Evaluation ♦ Plan of care	In CAReS: Under Health Screening Services category, mark "Nursing Assessment". Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	Used for nursing assessment/evaluation *outside of the home setting*	Code T1001: Nursing assessment/evaluation (15 minute unit) For time spent, include only face-to-face time. Do not include travel time (if applicable) or time documenting the service.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Home visit for nursing services	Home visit made for the purpose of providing nursing services including: ♦ Medical history ♦ Nursing assessment ♦ Evaluation ♦ Nursing services ♦ Plan of care Must be provided by a registered nurse.	In CAReS: Under Health Screening Services category, mark "Nursing Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. Time in and time out including a.m. and p.m. 2. First and last name of service provider & credentials if not entering own data. 3. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for nursing services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for nursing services in addition. 3. This code is based upon an **hourly** unit of service.	Code S9123 (per hour) For time spent, include only face-to-face time. Do not include travel time (if applicable) or time documenting the service.
Social work home visit	Home visit made for the purpose of providing social work services including: ♦ Social history ♦ Psychosocial assessment ♦ Counseling services ♦ Plan of care Must be provided by a BSW or licensed social worker.	In CAReS: Under Health Screening Services category, mark "Social Work Assessment". Select "home visit" as the interaction type. Include in CAReS: 1. First and last name of service provider & credentials if not entering own data. 2. Reference client-based chart for full description of services provided. In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	1. A home visit for care coordination service cannot also be billed for any portion of the home visit for social work services. 2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for social work services in addition.	Code S9127 This is an encounter code and is not based upon a timed unit.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Evaluation and Management	Evaluation and management (E & M) for an office visit with an established client. Examples include but are not limited to E & M pertaining to: ♦ Follow-up visits subsequent to a full well child screen (on a date following the screen) ♦ Lead risk assessment, education about lead poisoning, and follow-up instructions when doing a blood lead draw ♦ Reviewing immunization records, explaining the need for immunizations, and providing anticipatory guidance and follow-up instructions when preparing to administer vaccine	In CAReS: Under the Health Screening Service category, mark "Evaluation & Management". Select "clinic visit" as the interaction type. Enter service documentation notes: • Specify what the E & M is related to (e.g. well child screen, lead test, or immunization) • Describe the scope of the service or refer to client chart for detailed description. • Record first and last name of service provider and credentials if not entering own data. Refer to client based chart for complete documentation of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	E & M is a clinical encounter direct care service. This code cannot be used for: ♦ Providing care coordination services ♦ E & M on the same day as a full well child screen ♦ Explaining the purpose of a developmental screen, interpretation of the screen, anticipatory guidance, and referral to Level II screening when conducting a developmental screen. (These activities are already included in the code 96110.)	Code 99211 This encounter code can only be used once per day per client.
For more information on direct care services, refer to Medicaid's Screening Center Manual.				

2009 Maternal Health Summary of Services, Documentation and Codes

The following provides a summary of maternal health services provided for women through an IDPH Maternal Health Center. For guidelines for services, refer to the MCH Administrative Manual and the Medicaid Maternal Health Center Provider Manual as found on the Iowa Medicaid Enterprise (IME) Web page at http://www.ime.state.ia.us/providers

DOCUMENTATION

Documentation for each encounter with a client must adhere to requirements in IAC 441-79.3(2). In Maternal Health centers, data from encounters is entered into the electronic record known as the Women's Health Information System (WHIS); however, WHIS is not a complete medical record. Specific information regarding the client visit must be entered in the client's medical record maintained in the agency.

INFORMATION REQUIRED FOR EACH ENCOUNTER BASED ON THE SERVICE PROVIDED
Description of service or office notes or narratives
Complaint and symptoms; history; examination findings
Assessments
Clinical impression or diagnosis
Individualized plan of care(if client is high risk)
Specific procedures, diagnostic tests or treatments performed
Laboratory tests
Test orders
Results
Medication
Supplies
Client's progress, response to and changes in treatment, and revision of diagnosis.
Specific Forms for assessments completed such as Form 470-2942, Prenatal Risk Assessment

INFORMATION NECESSARY TO SUPPORT EACH ITEM OF SERVICE REPORTED ON THE MEDICAID CLAIM FORM
Name of client
Name of provider agency
Place of service
Complete date of the service including beginning & ending date if rendered over more than one day
A record of the time to support the units billed specifying a.m. or p.m. (e.g. 11:30 a.m. – 12:10 p.m.)
First and last name and professional credentials of the person providing the service
Signature of person providing the service or the initials of the person if a signature log indicates the person's identity
Specific procedures or treatments including nature, content, or units of service
Name, dosage, and route of administration of medication dispensed or administered
Any supplies dispensed as part of the service

When a service is reimbursed as units of time, where one unit equals 15 minutes, units are calculated as:
8-22 min = 1 unit
23-37 min = 2 units
38-52 min = 3 units
53-67 min = 4 units

Refer to the service code for value of a unit. For instance a nursing visit in the home equals one hour and a social work visit in the home is billed as an encounter rather than by units.

FUNDING SERVICES

Data in this table, related to funding, references Medicaid codes and requirements. Iowa Medicaid uses the HCFA Common Procedure Coding System (HCPCS). Services or charges cannot be fragmented for each procedure code billed. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

Maternal health centers must bill Medicaid for all Medicaid eligible women and are reimbursed on a fee-for-service basis. The amount billed should reflect the actual cost of providing the services. Maternal Health Centers may also bill other third party insurers, but are not required to do so (reference "Free care principle" of Title XIX, Section 1902(a)(11) (B)]. Documentation, including personnel time studies, must be available in the agency to demonstrate how costs are determined. The Medicaid fee schedule amount is the maximum payment reimbursed by Medicaid for each code.

Title V funds are utilized to fund services as described by the specific agency contract with the Iowa Department of Public Health.

Maternal health centers may bill IDPH starting February 1, 2009 for Presumptive eligibility determination, Title V and Title XIX care coordination, Title V and Title XIX home visit for care coordination.

SUMMARY OF SERVICES

The following information is based upon Medicaid and Maternal Health program guidelines as of the date of this document.

SERVICES FOR ALL WOMEN
Urine Pregnancy Test
Presumptive Eligibility Determination
Prenatal Risk Assessment
Maternity Care - Prenatal and postpartum medical care.
Evaluation and Management
Nursing Assessment and Evaluation
Health education services provided by a registered nurse
Care Coordination
Oral Health Services
Transportation
Interpreter Services
Immunizations
Postpartum Home Visit

Urine Pregnancy Test by visual color comparison/Urine test for determination of pregnancy.		
Documentation	Special Considerations	Code/Other funding sources
Document in Clients medical Record	Staff must demonstrate competency on the procedure per agency protocols and be able to distinguish color variations correctly.	81025 Urine Pregnancy Test by visual comparison Bill to IME

Presumptive Eligibility Determination		
Documentation	Special Considerations	Code/Other funding sources
Health Services Application Form and Case File required by DHS Document in Time and Service Input Form in WHIS. .	Agency must have an MOU with DHS prior to providing this service and then maintain a qualified provider status from DHS. Eligible clients must be pregnant and have an Iowa address. US citizenship is not a requirement. Staff provides education about presumptive eligibility and then assists the pregnant woman in completing the Health Services Application, form 470-2927 or the Spanish Health Services Application form 470-2927(S). This allows the qualified provider to make a presumptive eligibility determination. Inform client of period of eligibility to receive ambulatory medical services. You may bill care coordination on the same date of service to IDPH to link client to needed ambulatory medical and dental services.	No code - Bill cost of Presumptive eligibility determination to IDPH per client Can bill for Title V and Title XIX clients.

Prenatal Risk Assessment Determine risk for pregnant Medicaid members upon initial entry into care using form 470-2942, Medicaid Prenatal Risk Assessment. Repeat at 28 weeks of care when a low-risk pregnancy is reflected or when an increase in the pregnant woman's risk status is indicated.		
Documentation	Special Considerations	Code/Other funding sources
Enter results on form 470-2942 and keep the paper copy in the clients file. Maintain copy of the form 470-2942 risk assessment in medical record in the agency including date of service and location code for service.* Send a copy of the Risk Assessment to the client's primary medical/obstetrical care provider.	May only be billed by one provider unless additional assessment is required at a later date. If sharing responsibility for completing the form, establish a contract or MOA specifying payment agreement for services between collaborating parties. Also obtain sharing of information release from client. Additional assessments may be billed at a later date if client need is demonstrated. Note reason for additional assessment in medical record. To score the Medicaid Prenatal Risk Assessment, add the total score value on the left side and either the B1 column (initial visit score value) or the B2 column (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.	99420 Completion of Medicaid Prenatal Risk Assessment Or Title V for uninsured/ underinsured with sliding fee scale Bill to IME

	When a high-risk pregnancy is reflected, inform the woman and provide appropriate enhanced services as described in the individualized plan of care. (See Enhanced Services.) Complete the Medicaid Risk Assessment for all clients even those who are not eligible for Medicaid. If you document the risk assessment in WHIS and the client is not eligible for Medicaid put zero's in the spot for the Medicaid number.	

Maternity Care Antepartum care only 4 to 6 visits; Antepartum care only 7 or more visits		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Care must be provided by a physician, NP, CNM, or PA. All services in the package must be provided in order to bill. Individual services may not be billed separately. Must be face to face. Global OB needing interpretive services for each pre-natal visit. OB – Provider should keep track of time (units) used for interpretative services through the pregnancy and include it all on the final OB claim. The line for interpretative services would have the to and from dates that the services were actually provided.	Refer to the PROCEDURE CODES AND NOMENCLATURE found in the Maternal Health Screening Center Policy Manual for more detail. Antepartum care 59425 Antepartum care only; 4 to 6 visits 59426 Antepartum care only; 7 or more visits min

Evaluation and Management - Evaluation and management (E & M) for an office visit with a new or an established client. E& M codes are based on documentation and medical complexity of diagnosis, problem-focused history, problem-focused examination, medical decision-making, counseling and coordination of care.

Refer to the PROCEDURE CODES AND NOMENCLATURE found in the Maternal Health Screening Center Policy Manual for more detail.

Documentation	Special Considerations	Code/Other funding sources
In WHIS: Under the Time Input Service category, mark "Evaluation & Management". Select "clinic visit" as the interaction type. Enter service documentation notes: Documentation requires four parts History including chief complaint) Exam, diagnosis and plan of care. Describe the scope of the service or	E & M is a clinical encounter direct care service. This code cannot be used for: Providing care coordination services For E&M billing codes 99202, or higher the	**New Patient**: Office/outpatient visit for the evaluation and management 99201 self limited or minor – approx 10 min. 99202 – Straightforward low to moderate severity- approx 20 minutes 99203 low complexity, moderate severity. Approx 30 minutes 99204 moderate to high severity Approx 45 min. 99205 high complexity, moderate to high

refer to client chart for detailed description. Record first and last name of service provider and credentials if not entering own data. **Refer to client based chart for complete documentation** of the service. Documentation must adhere to requirements in IAC 441-79.3(2).	required review of systems and complexity would require a Nurse Practioner, CNM, or MD.	severity. Approx 60 min Established Patient: Office/ outpatient visit for the evaluation and management 99214 mod to high complexity - Approx 25 min 99215 mod to high complexity -Approx 40 minutes Bill to IME Title V for uninsured/ underinsured with sliding fee scale Encounter code can only be used once per day per client. Title V for uninsured/ underinsured with sliding fee scale Bill to IME

Nursing Assessment/Evaluation Nursing contact for the purpose of providing assessment and evaluation of a known medical condition such as: preterm labor, pre-eclampsia, urinary tract infection.		
Documentation	Special Considerations	Code/Other funding sources
In client's medical record maintained by the agency Include in WHIS: Time in and time out including a.m. and p.m. First and last name of service provider & credentials if not entering own data. Reference client-based chart for full description of services provided. Must include: Medical history including chief complaint Nursing assessment Evaluation Plan of care In client-based chart: Documentation must adhere to requirements in IAC 441-79.3(2).	Must be provided by a registered nurse. Must be office setting not part of a home visit	Code T1001: Nursing assessment/evaluation (15 minute unit) For time spent, include only face-to-face time. Do not include travel time (if applicable) or time documenting the service.

Health Education Health education services provided by a registered nurse, which includes:

- Importance of continued prenatal care.
- Normal changes of pregnancy:
  - Maternal changes
  - Fetal changes
- Self-care during pregnancy.
- Comfort measures during pregnancy.
- Danger signs of pregnancy.
- Labor and delivery:
  - Normal process of labor
  - Signs of labor
  - Coping skills
  - Danger signs
  - Management of normal labor
- Preparation for baby:
  - Feeding
  - Equipment
  - Clothing
- Education on the use of over-the-counter drugs.
- Education about HIV prevention.

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) noted above. Must document time in and time out, specifying a.m. or p.m.	Provided by a Registered Nurse. These services are included in the prenatal and postpartum medical package and are not billable as separate services on the same date as the direct care visit. Brochures and pamphlets may be provided as reinforcement of face to face education. Any cost incurred is part of health education or other direct care service code and is included in the cost plan. Mailing brochures and pamphlets may not be billed as a separate service. To be billed to an individual client, Health education must be provided on a one on one basis, based on clients needs and not as part of a class.	H1003 Prenatal care at risk service education - Per 15 min unit with a maximum of 5 units per date of service. Bill to IME Or Title V funding may be billed individually or when provided as a class.

Care coordination services – all women. Linking a client to the health care system (medical, dental, mental health or other Medicaid programs or services). Activities involve collecting information on the health needs of the client and assisting families to connect to services based on those needs. Services must include linking the family to Medicaid eligible service and may include linking the family to other non-Medicaid Services as well.

Must include one of these:

- Referral to dental services.
- Referral to physician or mid-level practitioners.
- Referral for hepatitis screen.
- Arrangements for delivery as appropriate.
- Referral to Mental health provider
- Referral for substance abuse or Tobacco Cessation Counseling

If referred to Medicaid eligible service then can include these:

- Referral to WIC.
- Referral Energy assistance
- Referral to Storks Nest.
- Assist with transportation to receive prenatal and postpartum services that are not otherwise payable under the Medicaid program.
- Assisting families to obtain Medicaid services and after completion of the DHS multi-program application as needed.
- Care coordination includes assisting clients in gaining access to services and monitoring to assure that needed services are received.
- Arranging support services such as medical transportation or interpreter services

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Document assessment and referral in WHIS use the Time and Service Input Form. Documentation must adhere to requirements in IAC 441-79.3(2) noted above. Must document time in and time out, specifying a.m. or p.m.	Provided by a registered nurse or a person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology; a person with a degree in dental hygiene; a licensed practical nurse or a paraprofessional working under the direct supervision of a health professional. Must involve phone or face-to-face contacts with the family or provider(s) on behalf of client. Must include linkage to medical, dental, mental health or other Medicaid related programs/services. May not bill care coordination for written reminders for services, unsuccessful attempts to reach families, activities that are part of direct care Do not bill cc for: Referral/arranging appointment for treatment following direct care provided by the MH agency Care coordination to arrange transportation may occur on the same day as a direct care service. Interpretation for care coordination may be billed on the same day as the care coordination service. Medical care coordination may be billed if a dental direct service is provided by other staff (RDH) on the same day (only if no medical direct care was provided). Dental care coordination by RDH may be billed if a medical direct service is provided by other staff on the same day (only if no dental direct care was provided).	No Code (formerly code H1002) for Title V or Title XIX clients. Bill cost of care coordination service to IDPH per client for services No code (formerly code T1016) Dental Care Coordination to IDPH.

Oral Health Direct Care Services Dental hygiene services within the scope of practice defined by the Iowa Board of Board Dental Examiners. Services may include:

Initial oral screen, periodic oral screen, child fluoride application,
Adult fluoride application
Child prophylaxis
Adult prophylaxis
Topical fluoride varnish – therapeutic application for moderate to high caries risk clients
Nutritional counseling for the control and prevention of oral disease
Tobacco counseling for prevention of oral disease.
Oral hygiene instruction
Sealant (per tooth)
Bitewing x-rays

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. In WHIS on the "Dental Intake" form mark appropriate service under the service category Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed for D1310, D1320 and D1330. For sealant applications document the tooth number, surface, and product used. For bitewing films document the number taken. For fluoride varnish application, document brand of fluoride and concentration used.	Client must be enrolled in the Maternal Health Program and has signed a treatment consent Dental hygiene services within the scope of practice defined by the Iowa Board of Dental Examiners. Dental screenings, fluoride applications, nutritional counseling, tobacco counseling, and oral hygiene instruction may be provided by an agency registered nurse, nurse practitioner, or physician assistant who has participated in IDPH-approved oral health training. Non-dental health professionals must assure that they are working within their respective scopes of practice. When providing direct care oral health services, any care coordination related to the direct care is considered part of the direct care service. Do not bill care coordination separately. For example: After completing an oral health screen, making arrangements for a referral to a DDS for follow-up and treatment cannot be billed as care coordination. Sealant applications are limited to ages 6-18 or those with a physical or mental disability. For Codes D1310, D1320 and D1330, a minimum of 8 minutes must be provided to bill the service.	Use Diagnosis code 528.9 with the following codes: D0150: Initial oral screen D0120: Periodic oral screen D1120: Prophy (age 12 yr. and younger) D1110: Prophy (age 13yr. and over) D1206: Topical fluoride varnish (mod to high caries risk) D1310: Nutritional counseling for control and prevention of oral disease (15 minute unit – maximum 4 units per date of service) D1320 Tobacco counseling for prevention of oral disease (15 minute unit) D1330: Oral hygiene instruction ((15 minute unit – maximum 4 units per date of service) D1351 Sealant per tooth (6-18 yrs, first and second permanent molars, permanent bicuspid and deciduous molars) D0270: Bitewing – single film D0272: Bitewing – two films D0274: Bitewing – four films Bill all direct dental services to IME Bill - formerly code T1016 Dental Care Coordination to IDPH.

Transportation to receive prenatal and postpartum services that is not otherwise payable under the Medicaid program. Includes non-emergency medical, dental, mental health local transportation by: Vehicle provided by volunteer (individual or organization) Taxi Bus, intra or interstate carrier Wheelchair van Transported by caseworker or social worker Parking fees, tolls, other related costs		
Documentation	Special Considerations	Code/Other funding sources
Include: Date of service Who provided the service Address of where recipient was picked up Destination (medical provider's name and address) Invoice of cost Mileage if transportation is paid per mile If a service log containing the above information is maintained, the service note must include reference to client record.	Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received. This does not include out-of-town transportation. Out of town transportation is paid for by the county DHS office. A transportation cost plan must be on file in the agency. A protocol or plan for transportation for non-Medicaid eligible women must be on file in the agency.	Use diagnosis code V68.9 with the following codes: A0080 Non-emergency transportation; vehicle provided by volunteer (individual or organization), with no vested interest Per round trip A0100 Non-emergency transportation; taxi Per round trip A0110 Non-emergency transportation; bus, intra or interstate carrier Per round trip A0130 Non-emergency transportation; wheelchair van Per round trip A0160 Non-emergency transportation, by caseworker or social worker Per round trip A0170 Transportation; parking fees, tolls, other Bill actual cost of transportation for the date the transportation was provided to the health related appointment to IME. For non-Medicaid eligible clients utilize local funding sources, community transportation services or volunteers.

Interpreter Service : services that include: Sign language or oral interpretive services Telephonic oral interpretive services		
Documentation	Special Considerations	Code/Other funding sources
In WHIS: Document Time Input under Health Screening Services category. Mark "Interpretation". For telephonic oral interpretive services, mark 'phone' as the Interaction Type. In WHIS Comment Box include Date of service Name of interpreter or company Time in and time out Cost of service	These services are provided by interpreters who provide only interpretive services. Interpreters are either employed or contracted by the Medicaid provider agency billing the services. Service providers on staff who are also bilingual are not reimbursed for the interpretation, but only for their medical or dental services. These services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service. This service does not include written translation of printed documents. It is the responsibility of the provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to IAC 645 Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org). Global OB needing interpretive services for each pre-natal visit. OB – Provider should keep track of time (units) used for interpretative services through the pregnancy and include it all on the final OB claim. The line for interpretative services would have the to and from dates that the services were actually provided.	Code T1013 for sign language or oral interpretive services (15 minute unit) Code W5023 For telephonic oral interpretive services (per minute unit) Reimbursable time may include the interpreter's travel and wait time.

Immunization Vaccine Administration:
Initial administration of immunization subcutaneous, intramuscular subsequent immunization administration, immunization administration, one vaccine intranasal or oral
Vaccine – Non VFC/Billable Vaccines: Refer to the PROCEDURE CODES AND NOMENCLATURE found in the Maternal Health Screening Center Policy Manual for a listing of all applicable vaccines (F:2).

Documentation	Special Considerations	Code/Other funding sources
Document in WHIS, medical record, IRIS, Master Index Card as appropriate. Document in client's medical chart maintained in the agency Documentation must adhere to requirements in IAC 441-79.3(2) Include: Time in and time out specifying a.m. or p.m. First and last name of service provider & title / credentials Reference medical record, IRIS, or Master Index Card for full description of services provided. Assure entry in IRIS as appropriate.	Typically VFC vaccine is used (at no cost). If vaccine is provided outside of the VFC cohort, bill for the vaccine.	90471 initial administration of vaccine (single or combination), subcutaneous or intramuscular 90472 subsequent administrations of vaccine (single or combination) on same day as Code 90471 or Code 90473. 90473 administration of one vaccine (single or combination) by intranasal or oral means. Bill vaccine at cost. Refer to the PROCEDURE CODES AND NOMENCLATURE found in the Maternal Health Screening Center Policy Manual for a listing of all applicable vaccine codes (F:2). Bill to IME For VFC vaccine (at $ 0).

ENHANCED SERVICES/HIGH RISK WOMEN

Provided to women with high risk pregnancies in addition to the services listed above for low-risk women and include:
Development, oversight and monitoring of an individualized plan of care
More intense care coordination services
More intense health education services
Nutrition services/Diabetes Management by a Dietitian
Psychosocial services
Nursing visit in the home
Social Work visit in the home

Following the Prenatal Risk Assessment, all high risk clients of the maternal health center must have an individualized plan of care for all services provided. The plan must be monitored regularly and revised as necessary based on needs assessments at each contact. Documentation of services provided shall include reference to the plan and notation when revisions are necessary based on goals met and emerging needs identified.

More Intense Care Coordination Developing an individualized plan of care based on the client's needs,

including pregnancy, physical, mental, personal, and interpersonal issues. Developing the plan includes: Counseling (such as coaching, supporting, education, listening, encouraging, and feedback) Referral and assistance for obtaining other specified services, such as mental health and domestic abuse Ensuring that the client receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit) Risk tracking		
Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Maintain a record of the time in and time out, specifying a.m. or p.m., per encounter to support the units billed Document in WHIS on Time and Services Input Form include time in and time out including am. and pm. Include interaction type as office or phone. Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Provided to women with high-risk pregnancies in addition to the services for low-risk women. Provided by a registered nurse or A person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology A person with a degree in dental hygiene A licensed practical nurse or a paraprofessional working under the direct supervision of a health professional. Service may be provided via phone, in the office setting. Documentation time may be included in the total time for care coordination if documentation is completed on the date of service. May not be billed when provided as an integral part of a direct care service that is provided on the same date. May be billed on the same date as a direct care service if service is provided by a separate provider for a separate issue. Example, a dental service and an RN service for a high risk pregnancy issue may be billed on the same day. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the mother or baby is considered part of this postpartum visit. Do not bill care coordination for any part of this maternal health visit.	Formerly code H1002 for Title V or Title XIX clients. Bill cost of care coordination service to IDPH per client for services provided on or after 2/1/2009.

More Intense Health Education -Services of greater intensity that are not provided as part of Care Coordination or other service. The following topics should be provided based on documented risk assessment as specified in the individualized plan of care:

- High-risk medical conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, gestational diabetes, gum disease, chronic urinary conditions, genetic disorders, and anemia.
- Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension.
- Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases.
- Smoking cessation. Refer to Quitline Iowa at 800-784-8669 or http://www.quitlineiowa.org/.
- Alcohol use.
- Drug use.
- Education on environmental and occupational hazards.
- High-risk sexual behavior.
- Oral Health

Documentation	Special Considerations	Code/Other funding sources
Documentation in client's medical record maintained in the agency. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed Documentation must adhere to requirements in IAC 441-79.3(2) noted above.	Provided by a registered nurse To be billed to an individual client, health education must be problem focused and provided on a one on one basis - not as part of a class. Referrals may be made to: Programs for stopping smoking or the use of alcohol or drugs. Psychosocial services for high-risk parenting issues or home situations, stress management, communication skills and resources, or self esteem.	H1003 Prenatal care at risk service education -per 15 minute unit with a maximum of 5 units per day. Bill to IME Title V funding (may be provided in a class setting)

Nutrition Services Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self reported dietary information. Discuss client's attitude about breastfeeding.
At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
Development of an individualized nutritional care plan.
Referral to food assistance programs, if indicated.
Nutritional interventions:

- Nutritional requirements of pregnancy as linked to fetal growth and development.
- Recommended dietary allowances for pregnancy.
- Appropriate weight gain.
- Vitamin and iron supplements.
- Information to make an informed infant feeding decision.
- Education to prepare for the proposed feeding method and the support services available for the mother.
- Infant nutritional needs and feeding practices.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Need must be documented for service beyond WIC counseling	Provided by a licensed dietitian Services must be above and beyond WIC services. Services must be provided one on one based on a needs assessment and not provided as part of a class.	S9470 Nutrition counseling provided by a dietitian per encounter (one unit per date of service) Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale

Diabetes Management by a Dietitian Diabetes management		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above	Services must be provided by a Dietitian Service must be above and beyond services provided by WIC if the client is WIC eligible.	S9465 Diabetes Services provided by a dietitian per encounter (one unit per date of service) Bill to IME

Psychosocial Services
A psychosocial needs assessment including a profile of the mother's:
- Demographic factors
- Mental and physical health history and concerns
- Adjustment to pregnancy and future parenting
- Environmental needs

A profile of the mother's family composition, patterns of functioning, and support systems.
An assessment-based plan of care.
Risk tracking.
Counseling and anticipatory guidance as appropriate.
Referral and follow-up services.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above.	Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family counseling, health or human development, health education or individual and family studies or a registered nurse. A social worker does not require a license to provide this service Services must be provided in an office setting. If a nurse is providing the psychosocial services visit it is only billable @ H0046 if there is not a nursing visit on the same date of service.	H0046 Bill to IME Or Title V funding for uninsured/ underinsured based on a sliding fee scale

Fetal Non Stress Test (NST) A fetal non stress test shall be administered based on identified need as described in the clinic protocol.

Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Include the reason the test was administered, pertinent information obtained during administration of the test (per training) and the date and time stamp for when the results were faxed to the client's physician along with other relevant communication with the client's primary provider.	The test must be administered by a Registered Nurse who has successfully completed training in the test administration. Test results must be sent to the client's physician along with communication with the provider's office that the test is being done and time results are being sent. Emphasize with the provider's staff that the test must be read by the provider on the same day as the test is administered. Request response on interpretation and any follow up communication or referral needed for the client.	59025 Fetal Non Stress Test Bill to IME

Nursing Visit In The Home Nursing visit in the home based on documented risk assessment and as specified in the individualized plan of care		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Home visit made for the purpose of providing nursing services including: Medical history Nursing assessment Evaluation Nursing services Plan of care Post Partum Home Visit shall include: An assessment of the mother's health status. Discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome. Family planning. A review of parenting skills including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant. An assessment of the infant's health. A review of infant care including feeding and nutritional needs, oral health, breast-feeding support, recognition of illness, accident prevention, immunizations, and well-child care. Identification and referral to community resources as needed. Maintain a record of the time in and time out, specifying a.m. or p.m. per encounter to support the units billed. The place of service must be noted on the medical record	Must be provided by a Registered Nurse. May be provided pre or post partum Since the primary purpose of the home visit is to provide direct care services, the home visit for care coordination service for child health cannot also be billed. The postpartum home visit is made within two weeks of the child's discharge from the hospital (ideally in the first week)If unable to schedule in the first two weeks, complete no later than six weeks. If unable to complete in the time frame, discharge the mother and baby to an appropriate agency and the Child Health Screening Center Care Coordinator for completion of the visit.	S9123 –Nursing Visit in home (One unit of time equals one hour). No limit per day based on documentation of service provided. For time spent include only face to face time, do not include travel time or time to document the service provided. Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale.

Social Work Visit In Home Social Work visit in the home. Purpose of the visit is based on documented risk assessment and as specified in the individualized plan of care.		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Home visit made for the purpose of providing social work services including: Social history Psychosocial assessment Counseling services Plan of care	Must be provided by a BSW or licensed social worker. May be provided pre or post partum. Since the primary purpose of the home visit is to provide direct care services, care coordination for child health can not also be billed.	S9127 Social Work Visit in the home One unit of time equals one encounter. Maximum of two encounters per pregnancy. For time spent, include only face to face time. Do not include travel time or documentation time. Bill to IME Title V funding for uninsured/ underinsured based on a sliding fee scale

Care Coordination Visit In The Home Care coordination visit in the home based on documented need		
Documentation	Special Considerations	Code/Other funding sources
Document in client's medical record maintained in the agency. Documentation must adhere to requirements in IAC 441-79.3(2) as noted above. Document in WHIS in the Time and Service Input Form must document interaction type as <u>home</u> visit. Include time in and time out, specifying a.m. or p.m. per encounter to support the units billed	In some situations it will be necessary to work one-on-one with a family in their <u>home.</u> Medically necessity may be due to a medical condition or when working with non-English speaking families and families without phones. Care Coordination may involve: Providing information about available health care services, Assisting clients in making health care appointments, Making referrals, Coordinating access to health care, and follow up to make sure that the needed services were received. Coordinate access to needed medical support services (transportation or interpreter services)	No Code/ Bill cost of care coordination home visit to <u>IDPH</u> per client. Includes Title V and Title XIX clients